

Western Elms Surgery

Quality Report

317 Oxford Road
Reading
Berkshire
RG30 1AT
Tel: 01189 590257
Website: www.westernelms.com

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

Ratings

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

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall.

At our previous inspection in November 2014 the practice had an overall rating as good.

Following the November 2014 inspection, the key questions were rated as:

- Are services safe? – Good
- Are services effective? – Good
- Are services caring? – Good
- Are services responsive? – Good
- Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups were rated as:

- Older People – Good
- People with long-term conditions – Good
- Families, children and young people – Good
- Working age people (including those recently retired and students) – Good
- People whose circumstances may make them vulnerable – Good
- People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Western Elms Surgery in Reading, Berkshire on 10th January 2018. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether Western Elms Surgery was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen.
- When incidents did happen, the practice learned from them and improved their processes.
- The practice fully engaged with programmes developed in the local area to support patient's health and wellbeing in a number of different ways. For example, a coffee morning hosted at a local church for patients over 75 years to share health information and receive feedback.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses in a number of areas.
- Patients found the appointment system easy to use and reported that they were able to access urgent care when they needed it.

Summary of findings

- Services were tailored to meet the needs of individual people and delivered in a way that ensured flexibility and choice. For example, the practice operated a drop-in family planning clinic and worked collaboratively with other external organisations and charities.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- We received positive feedback from external stakeholders and patients who access GP services from the practice.

We saw one area of outstanding practice including:

- Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given): The practice had nominated a project leader and established a working group, involving representatives of the Patient Participation Group (PPG) and local healthcare charities, to survey patients and recommend improvements. For example greetings and frequently asked questions at reception had been produced in six different languages and representatives from Mencap and Healthwatch frequently attended the surgery to act as advocates for appropriate patients. Signage in the waiting room

offered information in alternative formats and a protocol had been developed to help patients with hearing difficulties. All staff had received dementia awareness training and Makaton (a language programme using signs and symbols to help people communicate) training had been scheduled for a future practice training day.

The areas where the provider **should** make improvements are:

- Continue to review arrangements for the identification of carers to assure the practice that they are being identified effectively and provide any support they may require.
- Review processes to ensure that Patient Group Directions (PGDs) are signed by appropriate members of staff.
- Review processes for increasing the take up of children's immunisations.
- Continue to prioritise patients on the Learning Disabilities register and review arrangements to ensure all patients receive an annual health check.

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

Western Elms 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 specialist adviser and one further CQC inspector in a supporting role.

Background to Western Elms Surgery

Western Elms is a well-established GP surgery which has operated in this locality for over 100 years. The practice has a registered population of approximately 18,000. The premises are located on three floors with all treatment and consultation rooms on the ground floor. There is wheelchair access to the waiting area and to most consultation rooms. There are eight GP partners and a total of 12 GPs working at the practice, as well as locums. There is a mix of male and female GPs working at the practice.

The nursing team consists of two nurse practitioners, two practice nurses, two health care assistants (HCA) and one phlebotomist. The practice team also includes three pharmacists and are piloting the employment of a paramedic four hours per day to manage the home visits and carry out the treatment of minor illness. Administrative and reception staff also work at the practice and Western Elms Surgery is also a training practice.

The practice has a Primary Medical Services (PMS) contract. PMS contracts are subject to local negotiations between commissioners and the practice.

There is a higher than average number of working age patients and fewer older patients than average registered. The practice is located in an area of Reading with a high

density of rented accommodation which results in a highly transient population and a greater than average turnover of patients. Approximately 1,500 patients left and 2,000 registered with the practice in the last 12 months equating to nearly 11% turnover. The practice commented that local factors, has led to a year on year increase in their registered population (3% growth in the previous 12 months) and planning permission has been granted to extend the building to cope with the increased demand.

Western Elms Surgery is located in a pocket with a higher level of deprivation than the clinical commissioning group (CCG) average and comparable with the national average. People living in more deprived areas tend to have a greater need for health services.

The main entrance to the practice is accessed via ramps and all consulting and treatment rooms are located on the ground floor and accessible to patients with a disability or those with prams and pushchairs. Cover for holidays and other periods of absence is provided by regular locum GPs.

The practice is open between 8am to 6.30pm Monday to Friday. Pre-booked appointments are available from 8.30am to 5.50pm Monday to Friday and patients with an urgent need to see a GP can be seen up until 6.30pm. Extended surgery hours, staffed by doctors and nurses, are offered between 7.00am and 8.30am two days per week, between 6.30pm and 7.50pm two days per week and on Saturday mornings.

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by Westcall. The out of hours service is accessed by calling NHS111. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the website.

Detailed findings

We carried out an announced comprehensive inspection at Western Elms Surgery on 10 January 2018 as part of our inspection programme.

All services are provided from: Western Elms Surgery, 317 Oxford Road, Reading, Berkshire, RG30 1AT.

The practice has been inspected before in November 2014 when it was found to be good for the delivery of safe, effective, caring, responsive and well led services, giving rise to an overall rating of good.

Are services safe?

Our findings

We rated the practice as good for providing safe services overall and good for providing safe services to all population groups.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, there was a sepsis toolkit. Sepsis is a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

Staff had the information they needed to deliver safe care and treatment to patients.

- The systems for managing medicines, including vaccines, medical gases, and equipment minimised risks.
- Although the practice had assessed what medicines may be needed in the event of an emergency and these were available on site, most of them were stored in a locked cupboard in the treatment room. This may lead to a delay if required urgently. The rest of the emergency equipment and the medicines box was held behind reception to enable easy access. We found that the contents of the emergency medicines box had not been reviewed and a risk assessment had not been carried

Are services safe?

out. Following the inspection we received evidence that a review and risk assessment had been carried out by the practice and measures put in place to minimise the risk, including not locking them in a cupboard.

- We saw that the practice kept prescription stationery securely and monitored its use in line with current guidance.
- We saw evidence that staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- However, we found that the Patient Group Directions (PGDs) had not been signed by an appropriate member of staff (PGDs allow specified health care professionals to supply and or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber). This was rectified on the day of inspection.
- The practice had reviewed antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, a cervical smear sample was rejected by the laboratory because the sample pot was out of date. The practice apologised to the patient and arranged a repeat appointment. The practice's protocol was changed and staff now check all sample pots in all clinical rooms on a weekly basis.
- The practice learned from external safety events as well as patient and medicine safety alerts. There was an effective system for receiving and acting on safety alerts and we saw that alerts were shared with relevant staff and then discussed at meetings.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and good for providing effective services to all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians (GPs, nurse and phlebotomist) assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

We reviewed 2016/17 prescribing data from the local clinical commissioning group (CCG). We found the practice performed better when compared to local and national averages. For example:

- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group was 0.39. This was better when compared to the CCG average (0.55) and national average (0.90). Hypnotics, more commonly known as sleeping pills, are a class of psychoactive drugs whose primary function is to induce sleep and to be used in the treatment of insomnia, or surgical anaesthesia. Hypnotics should be used in the lowest dose possible, for the shortest duration possible and in strict accordance with their licensed indications.
- The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 0.81. This was comparable with the CCG average (0.94) and national average (0.98).
- Furthermore, the number of antibiotic items (Cephalosporins or Quinolones) prescribed was comparable (3.20%) with the CCG average (4.0%) and national average (4.70%). The practice demonstrated awareness, including helping to inform patients via the practice newsletters, to help prevent the development of current and future bacterial resistance. Clinical staff and prescribing data evidenced the practice prescribed

antibiotics according to the principles of antimicrobial stewardship, such as prescribing antibiotics only when they are needed (and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats) and reviewing the continued need for them.

Older people:

- Patients aged over 75 were reviewed and identified as at risk by generating a frailty score (frailty can be considered as a long-term health condition characterised by loss of physical, emotional and cognitive resilience as a result of the accumulation of multiple health deficits), referred to other services as necessary and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Home visits were offered to frail or housebound patients and flu vaccinations given by district nursing staff.

People with long-term conditions:

- The number of patients registered at Western Elms Surgery with a long-standing health condition was 49.9%. This was comparable with the CCG average (51.3%) and national average (53.7%).
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Data for 2016/17 showed the practice was not an outlier for any long term conditions and was achieving patient care at least in line and in some indicators better, when compared with local and national averages. For example, overall performance for depression related indicators showed the practice had achieved 100% of targets which was better when compared to the CCG average (90.0%) and the national average (92.8%).
- The practice held 'virtual clinics' (offering access to information and communication with health professionals and interaction with peers) with specialist consultants to help patients with poorly controlled diabetes. This helped improve the care of diabetic patients and the practice achieved full QOF points (86.0) in diabetes. This was 8.4 percentage points above the CCG average (77.6) and 9.0 percentage points above the national average (77.0).

Families, children and young people:

Are services effective?

(for example, treatment is effective)

- Childhood immunisations were carried out in line with the national childhood vaccination programme. For the year 2015/16 (which is the most up to date published data) uptake rates for vaccines were below the target percentage of 90% for two of the four sub-indicators for children aged up to two years. The percentage of children aged one with full course of recommended vaccines was 89.6% and the percentage of children aged two with haemophilus influenza type b and meningitis C booster vaccine was 88.7%. The practice was aware of the poor uptake and had employed a specialist nurse, with experience of working with hard to reach families from deprived and socially isolated communities, and had increased their efforts to contact parents and call in children whose immunisation records are not complete.
- The practice provided a drop-in family planning clinic, run by a nurse practitioner, offering all family planning services outside of patient's normal working hours.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 66.7%, which was lower when compared to the CCG average (73.2%) and national average (71.9%). The practice was aware of the poor uptake and had provided a drop-in family planning clinic offering opportunistic cervical screening. Patients who did not attend for screening were followed up by the practice and a recall system was in place.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- There were 51 patients on the Learning Disabilities register and six (12%) of these patients had received an annual health check. The practice identified the need to improve the uptake of these health checks and had conducted an in-house survey, developed an action plan and created a designated learning disability team consisting of a GP, a nurse and a healthcare assistant, all of whom have undergone specific training. To further

consolidate the action plan and the learning disability register we also saw the practice was working collaboratively with the local learning disability team and MENCAP (a project working to address the health needs of people with learning disabilities). We saw that at least one patient had a health check appointment booked every day for the next few weeks and a plan to recall patients in the month of their birthday following the initial review. The risk to these patients such as undiagnosed conditions or exacerbations of existing conditions which required treatment, were in the process of being mitigated.

People experiencing poor mental health (including people with dementia):

- 76.5% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was lower when compared to the CCG average (83.2%) and the national average (83.8%).
- 90.3% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher when compared to the local CCG average (84.7%) and the same as the national average (90.3%).
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 85.9%; CCG average 88.0%; national average 90.7%); and the percentage of patients experiencing poor mental health who have a record of blood pressure (practice 87.5%; CCG average 92.0%; national average 90.4%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. For example the pharmacists worked with local drug and alcohol recovery services to help care for adults with substance misuse problems.

The practice used information about care and treatment to make improvements. For example we saw completed

Are services effective?

(for example, treatment is effective)

practice audits management audits for Hormone Replacement Therapy (HRT), Acute Otitis Media (AOM) and hypertension. The practice manager also shared her knowledge and experience to help other local practices improve.

The most recent published Quality Outcome Framework (QOF) results were 98.6% of the total number of points available compared with the clinical commissioning group (CCG) average of 95.6% and national average of 95.5%. The overall exception reporting rate (12.4%) was higher when compared with the CCG average of 8.1% and the national average of 9.9%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Staff told us they were encouraged and given opportunities to develop. We saw a variety of training certificates which demonstrated training had been completed.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for health care assistants included the requirements of the Care Certificate (the Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life). The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice made effective use of multi-disciplinary roles and had recruited three pharmacists, with specialist training in the management of patients with

diabetes, respiratory disease and hypertension, and was leading a pilot project to use seconded paramedics from South Central Ambulance Service to manage the home visits and treat minor illness.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, flu campaigns, healthy eating, stop smoking campaigns and tackling obesity.

Data from the 2016/17 NHS Screening Service indicated success in patients attending national screening programmes. For example:

- 70.9% of female patients at the practice (aged between 50-70) had been screened for breast cancer in the last 36 months; this was comparable to the CCG average (76%) and the national average (70.3%).

Are services effective?

(for example, treatment is effective)

- 55.8% of patients at the practice (aged between 60-69) had been screened for bowel cancer in the last 30 months; this was comparable to the CCG average (62.2%) and the national average (54.5%).

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice as good for providing caring services overall and good for providing caring services to all population groups.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- Written and verbal feedback commented that the practice timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 22 patient Care Quality Commission comment cards of which 19 were positive, one was positive but also commented that it was difficult to get an appointment, one was negative about the service received and one was spoiled. The five patients we spoke with were positive about the service experienced.
- Of the responses the practice had received from the Friends and Family test, 4,889 out of 5,278 (93%) said they were extremely likely or likely to recommend the practice.
- We spoke to two members of the Patient Participation Group (PPG) and received very positive feedback. They said they felt valued and included in the development of the practice and commented that the practice staff are caring and helpful.
- We also received positive feedback from external stakeholders who access GP services from the practice. For example, a nearby care home providing accommodation and nursing care to elderly residents commented that the visiting GP is respectful, supportive and caring and that six monthly medicine reviews, annual health checks and seasonal influenza vaccinations are carried out. The care home's clinical services manager held regular communication meetings with the practice manager.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The survey sent out 354 forms and 144 were returned. This represented about 0.8% of the practice population. The practice was equal to or

above both the local clinical commissioning group (CCG) and national averages for its satisfaction scores on consultations with GPs and nurses and the helpfulness of receptionists. For example:

- 86% of patients who responded said the GP gave them enough time compared with the CCG average (85%) and national average (86%).
- 87% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average (87%) and national average (86%).
- 93% of patients who responded said the nurse was good at listening to them compared with the CCG average (91%) and national average (91%).
- 96% of patients who responded said the nurse gave them enough time compared with the CCG average (93%) and national average (92%).
- 96% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average (92%) and national average (91%).
- 92% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average (88%) and national average (87%).

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- There was significant ethnic diversity within the patient population, notably patients with an Asian background and a growing number of Eastern European patients. All staff we spoke with were aware that translation services were available for patients who did not have English as a first language. During the inspection, we saw information available in at least six different languages and notices informing patients that translation services were available. Representatives from Mencap and Healthwatch frequently attended the surgery to act as advocates for appropriate patients and a protocol had been developed to help patients with hearing difficulties. All staff had received dementia awareness

Are services caring?

training and Makaton (a language programme using signs and symbols to help people communicate) training had been scheduled for a future practice training day.

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- A hearing loop (a device to help people with hearing difficulties) was available at reception for patients and email consultations were available for patients with hearing difficulties.

The practice proactively identified patients who were carers. Carers were identified at registration and through information leaflets and posters in the waiting room. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 165 patients as carers, this equated to approximately 0.92% of the practice list.

Staff told us that if families had experienced bereavement, the practice sent them a sympathy card. Information giving advice on how to find and access support services was available in the waiting room.

Results from the national GP patient survey showed patients satisfaction to questions about their involvement in planning and making decisions about their care and treatment were in line with local and national averages:

- 87% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average (87%) and national average (86%).
- 82% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG average (82%) and national average (82%).
- 95% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to the CCG average (90%) and national average (90%).
- 85% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average (84%) and national average (85%).

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice as good for providing responsive services overall and good for providing responsive services to all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. Extended hours were offered two evenings per week, two mornings per week and most Saturday mornings. Patients had access to online services such as booking appointments and requesting repeat prescriptions.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, double appointments (20 minutes) were available for patients with special needs or requiring a translation service.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP and home visits were available for patients who required them.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs and paramedics also accommodated home visits for those who had difficulties getting to the practice.
- The practice worked with voluntary groups and a local church to provide social prescribing services (a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector). For example an arranged monthly coffee morning for over 75 year olds and a befriending service.

People with long-term conditions:

- The practice was fully aware of the challenges with the local health economy.
- Patients with long-term conditions had a structured annual review to check their health and treatment needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Appointments and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local multi-disciplinary teams to discuss and manage the needs of patients with complex medical issues.
- The practice organised for guest speakers to address patients on dementia and diabetes.

Families, children and young people:

- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Two drop-in family planning clinics were provided each week.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours in the evening, early morning and Saturday mornings offered appointments with GPs and nurses.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice website was clear and simple to use. The website also allowed registered patients to book online appointments and request repeat prescriptions.

People whose circumstances make them vulnerable:

- The practice offered longer appointments for vulnerable patients.
- The practice held registers of patients living in vulnerable circumstances including homeless people, travellers, sex workers and those with a learning disability.
- The practice clinical computer system was used to alert staff to patients living in vulnerable circumstances.

Are services responsive to people's needs?

(for example, to feedback?)

- The practice supported residents of a local probation hostel.
- 'Drop-in' sexual health appointments were offered to sex workers.
- The patient registration form included questions about caring responsibility and sensory impairment, to inform the practice of any additional care or support needs.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- A member of staff had been appointed as a dementia champion and the practice was working towards becoming fully dementia friendly.
- The practice offered longer appointments for patients experiencing poor mental health.
- Patients could access counselling services through the Berkshire wide talking therapies service. Details of this were available to patients in the patient leaflet and in reception.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use. During the inspection we saw GP, nurse and phlebotomist appointments were still available on the day of the inspection and the rest of the week.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable with local and national averages. This was supported by observations on the day of inspection and completed comment cards. The survey sent out 354 forms and 144 were returned. This represented about 0.8% of the practice population.

- 84% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 76% of patients who responded said they could get through easily to the practice by phone compared with the CCG average (74%) and national average (71%).
- 81% of patients who responded said they were able to get an appointment to see or speak to someone the last time they tried compared with the CCG average (86%) and national average (84%).
- 79% of patients who responded said their last appointment was convenient compared to the CCG average (82%) and national average (81%).
- 67% of patients who responded described their experience of making an appointment as good compared with the CCG average (74%) and national average (73%).
- 52% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average (62%) and national average (58%).

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- A duty manager rota was established to ensure all complaints and escalated queries could be responded to in a timely way.
- The complaint policy and procedures were in line with recognised guidance.
- 15 complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. For example, a policy had been changed to ensure all patients are contacted to check if they wish to review their medical report before it is sent out to third party organisations.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing well-led services overall and good for providing well-led services to all population groups.

Leadership, openness and transparency

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- There was a leadership structure in place.
- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- Staff told us the practice held regular team meetings.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- Leaders and managers acted on behaviour and performance which was inconsistent with the vision and values.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They told us they were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints and previous Care Quality Commission inspection reports. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. For example, two letters were not sent out in a timely manner due to one of the GPs being away. The patients concerned had been informed of the error and apologised to and the practice had changed its protocol accordingly and re-trained the medical secretary.
- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out,

Are services well-led?

Good 

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

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for any major incidents which may occur.
- The practice implemented service developments where appropriate and made efficiency changes with input from clinicians to measure and understand the impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice encouraged and valued feedback and involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. We spoke with a nearby care home providing accommodation and nursing care to elderly residents. They told us they had a good working relationship with the GPs and felt they were listened to. Suggestions and feedback were taken and acted upon by the practice.
- There was an active patient participation group (PPG).
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example a new appointment system was introduced following patient feedback and to help the practice cope with the demands from an increasing patient population.
- Practice leaders had oversight of incidents and complaints.
- The practice was active and worked collaboratively with the CCG and other local external health organisations. For example, piloting a project to use paramedics, supplied by South Central Ambulance Service to manage the home visits and treat patients unable to visit the surgery.

Are services well-led?

Good 

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

- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

The practice had gathered feedback from patients through the PPG and through surveys and complaints received. We spoke with two members of the PPG who told us they met regularly with the practice and fed back patient views to the practice.