# Morland House 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.

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# Summary of findings

## Overall summary

Morland House Surgery is located in London Road, Wheatley, Oxfordshire. The practice operates from a large converted and extended residential property.

During our inspection we spoke with 12 patients. We also reviewed the comment cards that 18 patients had completed before our visit.

All the patients we spoke with and all the comment cards we reviewed commented positively on the service they received from this practice. The most recent patient survey conducted by the practice between November 2013 and January 2104 also showed high levels of satisfaction with the care and treatment patients received.

The practice was aware of the needs of their practice population and had taken steps to improve or make more accessible the services for their patients. All patients were able to access same day appointments for urgent care and a Saturday morning surgery took place each week for patients who were unable to attend on weekdays due to work commitments. Patients we spoke with were clear about how to contact the out of hours service should they need to. The practice used an external service for out of hours provision.

GPs and nurses gave patients the information they needed to ensure they were able to make informed choices about their care and treatment. The practice was able to respond to requests for urgent care and patients spoke positively about the support they received for their health and well-being. The provision of palliative care and support for bereaved families was a priority for all staff.

There was evidence that the practice worked with other health and social care professionals to safeguard their patients and improve their health and treatment outcomes. A drop in clinic run jointly by GPs and Health Visitors was available for families with babies and young children. Midwives worked alongside the practice to provide antenatal and postnatal care.

Practice nurses had attended specialist training to enable them to provide care for patients with long term conditions. The practice was led by experienced and established senior staff.

However we found that improvements were needed in the way the practice assessed and managed the risks associated with the safe keeping and dispensing of medicines.

The provider was in breach of the regulation related to the risks associated with the management of medicines.

- Guidance for staff in relation to monitoring the storage temperatures of vaccines was out of date and did not follow national guidance.
- Medicines dispensed into compliance aids were not always checked against the patient's current signed prescription. Emergency medicines were checked by practice staff however these checks were not recorded.

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.

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

The practice requires improvement as not all systems ensured the safety of patients.

- There was a robust process for identifying and reporting any safeguarding concerns.
- The premises were visibly clean and well maintained.
- The practice ensured the required staffing levels and had used calculations to ensure there were sufficient GPs employed to meet patients' needs.
- Equipment at the practice had been checked for safety and was in working order. There was learning from incidents, however improvements were still required to ensure that policy and procedures were followed and reflected national guidance.
- The practice had systems in place to deal with emergencies that may arise. However the recording of safety checks of emergency medicines and staff understanding of the importance of checks of fridge temperature required improvement.

**Are services effective?**

The practice was effective

- The practice delivered care and treatment in line with recognised best practice and worked with other support services to provide a complete service to patients.
- The provider had systems and processes in place to ensure that standards of care were effectively monitored and maintained.
- Clinical audits had been completed, which had resulted in improvements to patient care and treatment.
- Staff received the necessary support, training and development for their role.
- The level of staffing at the practice enabled the effective delivery of quality care.
- The practice worked with other health professionals to ensure the right treatment outcomes for their patients.
- Patients were supported to manage their own health by well trained staff.

**Are services caring?**

The practice was caring.

- The patients we spoke with were complimentary about the caring compassionate attitude of staff.

# Summary of findings

- We observed patients being treated with dignity and respect.
- Staff provided privacy during all consultations and reception staff maintained patient confidentiality when registering or booking in patients.
- Patients we spoke with felt well informed about their care and treatment.
- Staff gave patients the information they required about their treatment to ensure they were able to make informed choices.
- Patients told us the GPs acted above and beyond expectations in the care and support they provided to patients and their carers.

**Are services responsive to people's needs?**

The practice was responsive to patients' needs.

- Patients told us they could always get an emergency appointment and the waiting time for routine appointments was good.
- The practice responded well to requests for urgent care and patients spoke positively about the support provided by the GPs for both health and emotional needs
- The practice sought feedback from patients about the practice and how they rated the various aspects of the service. This included opening hours, telephone access and waiting times.
- The practice understood the needs of their practice population and had made changes to the practice building and systems to meet the needs of their patients. There was a patient lift giving access to first floor consulting rooms.
- The practice had a virtual patient participation group and sought their views and opinions on changes to the practice.

**Are services well-led?**

The practice was not always well led and required some improvements.

- The practice had an established staff team. Staff were supported by senior staff and a culture of openness and honesty was encouraged. The quality, performance and effectiveness of the service was monitored with GPs having a collective responsibility for making decisions about clinical practice
- The practice encouraged feedback from patients and learned from feedback when it was given.
- Governance structures for clinical areas were robust. Weekly clinical meetings were used for GPs to cascade information to colleagues. Incidents were reported promptly and analysed.

# Summary of findings

- Communication within teams was good but information was not always shared across the whole service.
- The practice had a business continuity plan. However this did not include short term plans for the continued provision of patient care should the premises become unavailable.

# 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

- Patients from this age group told us that the practice provided a very compassionate caring service.
- We saw that the practice responded to the needs of this population group by improving access to the services they needed.
- The GPs conducted home visits and visited patients at a day centre to administer flu vaccinations.
- The practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care.

### People with long-term conditions

- Patients with long term conditions were supported by the practice to manage their conditions.
- Nursing staff had specific training to help them understand the needs of these patients.
- Nurses and GPs advised patients, and provided them with information, on the management of their long term condition and signposted them to relevant support organisations.

### Mothers, babies, children and young people

- The practice had a GP with a lead role for women's health.
- Relevant information and up to date guidance was passed to all GPs at weekly clinical meetings.
- The practice provided a drop in clinic for mothers, babies and young children and regular midwife clinics for antenatal care.
- There were good links with the health visiting team.

### The working-age population and those recently retired

- The service had a Saturday morning surgery each week. This increased the accessibility of their service to people who were unable to attend during the day due to work commitments.
- There was capacity within the appointment system for all patients to be seen the same day if necessary.

# Summary of findings

**People in vulnerable circumstances who may have poor access to primary care**

- The practice had identified patients who may find access to care difficult through their particular circumstances.
- The practice area covered a community of travelling people and the practice had a small number of patients who had a learning disability.

**People experiencing poor mental health**

- A counsellor from a local support group worked at the surgery. The counsellor was able to see referrals from the GPs and patients were able to self-refer to use their service.
- The practice worked with local mental health services to ensure patients were well supported.
- Staff were educated and informed about local support services and provided information to patients.
- The practice used the services of the community mental health team but was also able to provide cognitive behaviour therapy (CBT) for their patients.

# Summary of findings

## What people who use the service say

We spoke with 12 patients and representatives of the patient participation group (PPG). We spoke with a representative of national charity who supported a number of patients who visited this practice. We reviewed 18 comment cards which had been completed by patients in the two weeks leading up to our inspection.

Without exception patients were very complimentary about the practice staff being patient, understanding and friendly. All the patients we spoke with praised the caring attitude of the GPs and their ability to respond to their patients' needs promptly with compassion and understanding.

We spoke with patients from a number of the population groups we looked at. These included mothers and children, people of working age, people with long term conditions and people aged over 75 years of age. Patients told us that staff had a caring attitude and they felt safe with the care they received. All patients were satisfied with the appointment system and the ability to get appointments to suit their needs. We were told by patients that when they had received care from other health care professionals they were pleased that information was shared appropriately. For example transfer to and from hospital and or private medical care had been a smooth process.

There had been 247 responses in the patient satisfaction survey from November 2013 to January 2014. Patients had rated their satisfaction highly. The practice had asked patients to rate them on 28 aspects of the service. The survey showed that 27 of the 28 ratings for the practice were above the national average. The practice had also received 45 positive comments.

## Areas for improvement

**Action the service MUST take to improve**

- There must be an effective system and up to date procedures in place for the management of the cold chain for vaccines.
- The practice protocol in relation to fridge temperatures must follow national guidelines.
- There must be a system in place for the safe management of medicines, such as a system for the checking and recording of emergency medicines and the checking of medicines dispensed in compliance aids.

**Action the service SHOULD take to improve**

- Systems for the recording meetings where there are any concerns and risks identified should be documented and dealt with.
- The practice's business continuity plan should include formal, short term, arrangements for the continuation of the service for patients should the premises be unavailable.

## Outstanding practice

Our inspection team highlighted the following areas of good practice:

- Access to the practice was difficult for some patients due to the semi-rural location of their homes. GPs conducted home visits and visited patients at a day centre to administer flu vaccinations.

# Morland House 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 and the team included a second CQC inspector and a practice manager specialist advisor.

## Background to Morland House Surgery

Morland House Surgery is located in London Road, Wheatley, Oxfordshire. The practice is operated from a converted and extended residential property. A physiotherapist and local counselling services also use the building. The practice has its own dispensary.

Outside normal surgery hours patients are able to access emergency care from an alternative Out of Hours provider.

The practice provides a range of primary medical services to approximately 10,400 patients. Patients are supported by three GP partners, seven practice doctors, a practice manager and their deputy, practice nursing staff, phlebotomists, dispensers and administrative and reception staff. The practice is a member of the Oxfordshire Clinical Commissioning Group (CCG).

Morland House Surgery, in line with other practices in the Oxfordshire CCG, is in a significantly less deprived area than the England average. Morland House Surgery has a higher percentage of their population group over the age of 65 than the average for England.

## Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service. Organisations included local Healthwatch, NHS England and the clinical commissioning group. We carried out an announced visit on 7 July 2014. During our visit we spoke with a range of staff including GPs, practice nursing staff, medicine dispensing staff, the practice manager and reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed 18 comment cards on which patients had shared their views and experience of the service.

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?

# Detailed findings

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

# Are services safe?

## Our findings

### Safe Track Record

The practice received patient safety alerts around medicines and equipment. The practice manager and GPs told us how these were dealt with in the practice to ensure the information was passed to the appropriate staff, GPs, nurses or dispensing staff. There was no system in place for these staff to report back to the practice manager to ensure appropriate action had been taken as a result of the safety alerts.

### Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. We saw the reports of these events and discussed with the practice manager and GPs the process for recording incidents. All serious events were discussed at weekly GP meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. We saw an example where a specific incident had been investigated and suggestions had been sought about how to prevent the incident reoccurring. Systems within the practice had been changed to minimise future risks.

### Reliable safety systems and processes including safeguarding

One of the GP partners who took the lead in safeguarding had taken part in training in the subject. Staff we spoke with were clear about their responsibilities to report any concerns they may have. Contact details for the local authority safeguarding team were readily available to practice staff to avoid delays in the reporting of any concerns. GPs and nursing staff had an electronic link to the local safeguarding team should they need to raise any concerns.

The GP who led on safeguarding met regularly with the health visiting team and one of the district nurses attended the GPs' weekly meetings, this gave them the opportunity to discuss any safeguarding concerns. We were able to see the minutes of a special meeting which had been held to discuss a specific concern. The GPs we spoke with were able to provide us with examples of contact made with social services when they had identified concerns about patients in their care.

GPs at the practice offered patients the services of a chaperone during examinations. A chaperone is a person who accompanies another person during treatment or examination. This service was advertised in consulting rooms; however there was no information about this service available in waiting areas.

### Monitoring Safety & Responding to Risk

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. The practice had an automated external defibrillator (AED) which is used in the emergency treatment of a person having a cardiac arrest. We were told that the emergency equipment and emergency medicines were checked monthly by a practice nurse to ensure the equipment was working and the medicines were in date so that they would be safe to use should an emergency arise. We were not able to confirm this as there were no records of these checks.

### Medicines Management

The practice's medicines management policy was detailed in the Standard Operating Procedures (SOPs) for the practice's dispensary. SOPs are guidelines that are in place for the management of medicines. They are a specification of what should be done when, where and by whom. The GPs we spoke with told us that controlled drugs were not carried by GPs in their bags.

Medicines fridges were located in nurses' treatment rooms, the practice sluice room and the dispensary. These were lockable to ensure their contents were safe. Fridge temperatures were logged daily to check that they had remained at the optimum temperature for temperature sensitive medicines and vaccines. We found a number of instances when the temperature recorded was outside the optimum range. Some staff were not clear about when to report concerns in relation to abnormal temperatures. They had not been provided with sufficient up to date guidance to ensure that safety checks were effective and recorded appropriately. The practice protocol in relation to fridge temperatures did not follow national guidelines. Guidance for staff about when and who to report abnormal fridge temperature readings had not been updated. Staff were directed to report any abnormal temperatures to a person who was no longer employed at the practice. Staff had not been given clear guidance about the reason behind safety checks or when concerns should be escalated in order to mitigate any risks to patients. We also found that the only record of temperatures for the fridge in the dispensary were for the current month. Staff did not know where previous

# Are services safe?

records were held. At the time of the inspection the practice could not be sure that temperature sensitive medicines were safe and effective. We raised these concerns with the practice who took immediate steps to investigate the temperature recording issues, carry out a detailed risk assessment and provide guidance for staff.

The practice had a dispensary for their patients to use. We found that systems were in place for the safe ordering, disposal and storage of medicines. An accountable officer attended regularly to dispose of any controlled drugs. There were records kept of their safe disposal. An accountable officer is a person appointed to ensure controlled drugs are monitored.

We found that medicines dispensed into compliance aids were not always checked against the patient's current signed prescription. (Compliance aids are containers made up by the dispensary which contain a patient's medication for specific times of the day). This did not follow the practice's SOP for filling compliance aids which stated that all medication should be kept with their corresponding prescriptions until final dispensing check has been undertaken. Although the dispensary was able to make checks through the practice IT system this did not mean that a GP had authorised the current prescription.

### Cleanliness & Infection Control

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection. Infection control procedures were checked every six months. We saw the results of the last two checks in August 2013 and February 2014. The most recent check had highlighted the need for pedal operated clinical waste bins, these were now in place.

Hand washing reminders were available above all sinks both in clinical and patient areas. There was a supply of liquid soap and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was segregation of waste. Clinical waste was disposed of appropriately and after being removed from the practice was kept in locked waste bins to await collection.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises were visibly clean and well maintained. Work surfaces could be cleaned easily and were clutter free. There was a cleaning schedule for staff outlining the cleaning tasks that should be completed on a daily, weekly and quarterly basis.

### Staffing & Recruitment

The staff we spoke with told us that the majority of the staff had worked at the practice for a number of years. The practice manager and GPs we spoke with told us that they felt the stable work force provided a safe environment for their patients. Staff recruitment files showed that appropriate criminal records checks had been carried out via the Disclosure and Barring Service (DBS) for GPs and nursing staff. The practice had a chaperone policy and had carried out a risk assessment in relation to the need for DBS checks for reception staff.

Staff recruitment files contained a record of the staff member's full employment history, qualifications, proof of their identity and written references. These checks had been made to ensure that the person being employed was of good character and had the appropriate qualifications for their role.

The practice used a calculation of patients to GP sessions to decide on staffing levels to meet patients' needs.

### Dealing with Emergencies

The practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service, such as a loss of computer systems, power or telephones. There was adequate insurance in place to cover alternative accommodation for long term disruption but no arrangements had been recorded about how the practice could access other facilities or premises at short notice. The practice had established relationships with neighbouring practices and had agreed to work with other surgeries in the event of an emergency situation such as a swine flu outbreak.

The practice had guidance for staff about how they should manage patients with infectious diseases. This included how patients could be treated without posing a risk to other patients who may be attending the practice. All staff had received training in basic life support and we saw that there was a supply of emergency medicines and equipment, such as oxygen and a defibrillator, which may be needed should a patient experience a medical emergency while attending the practice.

# Are services safe?

**Equipment**

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. We saw that medical equipment had been calibrated in April 2014, there had been no action necessary at that time as all equipment was functioning correctly and accurately. (Calibration is a means of testing that equipment is accurate). Electrical items had been portable appliance tested (PAT tested) and were safe to use. This provided assurances that the equipment was in efficient working order and in good repair.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment, care & treatment in line with standards

The practice had regular meetings for various staff groups, GPs met weekly and reception staff every one to two months. Clinical and business issues relevant to patient care, and significant events and complaints were discussed. This enabled the practice staff to discuss best practice and to learn from any incidents or concerns to improve the service for patients.

Staff we spoke with were aware of the need to gain informed consent from patients. Although not all staff had undergone formal training in the Mental Capacity Act (MCA) 2005 they were aware of the principles of the Act and the need to ensure best interests decisions were made appropriately for people who lacked the capacity to consent.

All new patients to the practice were offered a health assessment to ensure the practice was aware of their health needs. Patients who relied on long term medication were regularly assessed and their medication needs reviewed. There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results of their patients. The duty doctor took responsibility for checking the results of any patient whose GP was not working that day. They were then able to take immediate action if required or to highlight any information for the patient's named GP.

### Management, monitoring and improving outcomes for people

The practice GPs told us they all had responsibility for keeping up to date with recent guidance. Updates in guidance from the National Institute for Health and Care Excellence (NICE) were discussed at the weekly clinical meetings. We were present at one of the weekly clinical meetings where the GP who was the practice lead for women's health shared recent guidance about the use of the contraceptive pill and obstetric medicine. Other discussions related to best practice guidelines for the avoidance of unplanned hospital admissions for their patients.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries.

The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. Morland House Surgery completed the clinical audits that were required to fulfil the requirements of their QOF. We saw evidence that further audits of clinical practice took place to test the effectiveness of treatment. The Practice has a system in place for completing clinical audit cycles. Examples of clinical audits included adolescent booster vaccinations, raised prostate specific antigen (PSA) and a splenectomy audit. GPs completed audits of clinical practice to present at their appraisal in preparation for revalidation. These audits gave the GPs information to help prevent future health problems and monitor patient health, such as highlighting the need to offer and record booster vaccinations to ensure patients remained protected.

The practice regularly reviewed their achievements against QOF. The practice manager was a regular attender at locality practice meetings where representatives from neighbouring practices met to discuss ways of improving outcomes for their patients. The deputy practice manager actively monitored the practice QOF and alerted GPs of any shortfalls that needed to be addressed.

The QOF data for this practice dated April 2014 showed that it generally achieved high or very high scores in areas that reflected the effectiveness of care provided. Data from the GP patient survey January to September 2013 demonstrated that the surgery performed well in comparison to other surgeries and practices within the CCG.

### Effective Staffing, equipment and facilities

The majority of the staff we spoke with in both clinical and administrative roles told us they were well supported by the GPs and the practice manager. There was a system of induction in place for newly recruited staff.

There was an annual appraisal system in place for staff. Staff we spoke with confirmed they had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they may have, around patient care or practice management, and their own

# Are services effective?

## (for example, treatment is effective)

personal development. Staff told us the practice paid for staff training and gave staff paid leave to attend relevant training. Nurses had taken part in a range of training courses to improve patient care such as nursing elderly people, family planning and diabetic nursing. All practice staff had received training in basic life support, information governance and infection control. GPs took part in a peer review appraisal; these appraisals would form part of their future revalidation with the General Medical Committee (GMC).

During our inspection we spoke with 12 patients and reviewed 18 comment cards. They all commented positively on the availability of appointments, how quickly their telephone calls were answered and waiting times once they were at the surgery. There was sufficient staff available to meet their needs. The practice used a measurement of patients per GP in order to ensure an adequate number of GPs that were employed to meet the needs of the patients.

### Working with other services

The practice worked with others to improve the service and care of their patients. There were arrangements in place for other health professionals to use the practice premises to provide services to patients. These included a physiotherapist, a counsellor and a dietician. Antenatal and postnatal care was provided by visiting midwives and health visitors who were located in a neighbouring building. GPs and nurses worked closely with health visitors and district nurses.

The practice held weekly clinical meetings to which other health care professionals were invited to attend when appropriate. We attended a clinical meeting on the day of our inspection. This meeting was attended by a representative of the district nursing team. This gave the GPs and district nurses the opportunity to discuss specific concerns to ensure the best treatment outcomes for patients. Referral letters were also discussed to ensure that all relevant information was recorded and that the referral was appropriate. The GPs explained that this system reduced the number of referrals which were rejected by other healthcare providers.

There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results, received from other health care providers, for their patients. The duty doctor took responsibility for checking the results of any patient whose GP was not working that day. They were then able to take immediate action if required or to highlight any information for the patient's named GP.

### Health Promotion & Prevention

All new patients to the practice were offered a health assessment to ensure the practice was aware of their health needs.

The practice had a range of health promotion leaflets in their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations such as an advocacy service or carer support.

The practice carried out child immunisations with a GP carrying out the first immunisation for each child. This gave parents the opportunity to discuss any health concerns and to ensure the parent was aware of what the vaccination was for. A recent audit had been undertaken on adolescent booster vaccinations which raised awareness with staff for the need to encourage or plan for these to be carried out; this improved the outcome for patients as it ensured they continued to be protected.

Practice nurses had specialist training and skills, for example in the treatment of asthma, diabetes and travel vaccinations. This enabled them to advise patients about the management of their own health in these specialist areas. One patient told us the nurse they visited always checked that they knew how to use equipment and medication. Another patient spoke about the well person screening they had been invited to attend.

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

During our inspection we spoke with 12 patients, reviewed 18 comment cards, spoke with representatives from the practice's patient participation group (PPG). Everybody was complementary about the care that they, or the patients they represented, received from all the practice staff. We spoke with patients of varying ages. They all said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

Staff told us how they respected patients' confidentiality and privacy. The majority of telephone calls were answered by staff who were not sitting at the reception desk and ensured that confidential information could not be overheard.

Bereaved families were given contact details for local services which could support them. GPs told us that they involved families and carers in end of life care. They ensured that the out of hours service was aware of any information regarding their patients' end of life needs. One GP had a specialist interest in palliative care and told us that the practice supported patients as far as possible if their wish was to die in their own home. One of the patients we spoke with told us of the support they had received during a recent bereavement, the home visits made by GPs and the support services that had been arranged for them.

The practice provided the out of hours service with special patient notes. This is information recorded about patients with complex health, social care or end of life needs to ensure that the out of hours provider was able to effectively meet the needs of those patients.

### Involvement in decisions and consent

All the people we spoke with told us the GP explained their treatment and all commented that there was enough time to discuss their needs. GPs were aware of the requirements of the Mental Capacity Act 2005 (MCA) and the laws surrounding decisions made for people who lacked the ability to consent or make a decision about their care and treatment.

Staff we spoke with were aware of the need to gain informed consent from patients. Although not all staff had undergone formal training in the Mental Capacity Act (MCA) 2005 they were aware of the principles of the Act and the need to ensure best interests decisions were made appropriately for people who lacked the capacity to consent.

GPs and nurses explained how they gave patients the information they required about their treatment to ensure they were able to make informed choices. Written consent was taken for travel vaccinations as part of a risk assessment and ensured that patients were aware of the risks and benefits of their treatment.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to people's needs

The practice whenever possible ensured that patients were given appointments with their named GP. This ensured continuity of care and patients we spoke with in most cases preferred see their own GP. We were told that the allocation of patients to specific GPs was done on patient numbers.

The practice and all the staff we spoke with were aware of the practice population in respect of age, ethnic origin and number of patients with long term conditions. The practice had responded to the needs of the practice population. A Saturday morning surgery was available for patients who could not attend during weekdays due to work commitments.

The practice had facilities for patients with a disability and an area of the reception desk was at a lower level for patients who may use a wheelchair. There was a patient lift to the first floor where some of the consulting rooms were located.

Staff could access translation services for a number of nationalities if required.

The practice had a virtual patient participation group (PPG). The group had been consulted about the questions for the annual patient survey carried out between November 2013 and January 2014. Following the survey the PPG had agreed a plan of action with the practice for changes and improvements as a response to issues highlighted in the survey. A number of the members of the PPG made themselves available to the inspection team and were keen to promote and compliment the responsiveness of the practice.

### Access to the service

Patients we spoke with told us that they did not have any problems making appointments when they needed them. They told us that they were able to get emergency appointments on the day they needed them and had to wait up to two days for a routine appointment or to see the GP of their choice. Each patient had a named GP and was also able to make a request to see other GPs. The patients we spoke with were clear about how the practice operated their appointment system. Without exception all the patients who spoke with us, or provided feedback on our comment cards, felt able to access a GP when they needed to.

Reception staff explained the appointment booking system. Patients could telephone the surgery or book routine appointments on line. Telephone consultations were also available to enable patients to speak with their own GP. Clear details of the appointment system were available in the practice leaflet and on the practice website. The practice had a duty doctor available every day who had no pre booked appointments; they were able to see any patient who rang requesting a same day appointment.

### Meeting people's needs

A number of the patients we spoke with had examples of the practice GPs responding to their needs for urgent care. For example carrying out a home visit to provide palliative care and family support. Patients told us that when they had required referral to other health care professionals or hospital this had been done promptly and they had been kept informed. The practice had an effective system of monitoring and following up referrals. All routine referrals were discussed at the weekly clinical meetings to ensure that appropriate information had been included. This, we were told, reduced the number of rejected or returned referrals which avoided delays for patients.

### Concerns & Complaints

The practice has a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We looked at the record of complaints that had been received by the practice. All the complaints had been responded to in a courteous manner by the practice manager. The practice manager kept a tracking sheet for each complaint to ensure it was dealt with in line with the practice complaints policy. Reception staff told us that if a patient approached them with a concern or complaint they would direct the patient to speak with the practice manager or would forward to the practice manager any written complaint. Practice staff told us that whenever possible the practice manager tried to address concerns to satisfy the patient as soon as possible. All complaints were reviewed at practice quarterly meetings and discussed with the appropriate staff. Feedback on complaints was not shared with the whole staff team as a way of reviewing and improving practice.

Information was available in the practice leaflet and was displayed in waiting areas for patients about how they

# Are services responsive to people's needs?

## (for example, to feedback?)

could raise their concerns or feedback to the practice. A suggestions book was available at reception however this book did not give patients the anonymity to raise their concerns or provide feedback.

The practice sought the views of their patients in an annual satisfaction survey. We saw the results of the latest survey for 2013-2014. The practice had analysed the results and compared them to the national average for practices of a similar size. The results of the latest survey showed that Morland House Surgery performed better than the national average for 27 of the 28 points that they asked their patients to rate. An action plan had been produced to address any suggestions or comments that had been made. The results of the survey were published on the practice website.

The practice had a virtual patient participation group (PPG). The group had been consulted about the questions for the patient survey. Following the survey the PPG had agreed a plan of action with the practice for changes and improvements as a response to issues highlighted in the survey. A number of the members of the PPG made themselves available to the inspection team and were keen to promote and compliment the responsiveness of the practice.

# Are services well-led?

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

## Our findings

### Leadership & Culture

The leadership was established at the practice as GP partners and the practice manager had been in their roles for a number of years. Most of the staff we spoke with told us they felt supported by the practice manager and GPs. Patients described the practice as caring and friendly. There was an open culture at the practice and the staff we spoke with felt able to go to the senior staff with any problems or concerns. All staff were clear about their roles and responsibilities, and that they were provided with opportunities for development and training. Appraisals were carried out annually and training was supported by the GP partners and practice management. We saw that serious events were reported and discussed at weekly GP meetings for learning and not to apportion blame. Each staff group had regular meetings and agenda items reflected their roles and responsibilities. Communication within teams was good but information was not always shared across the whole service. For example information from meetings in the dispensary had not been recorded or cascaded to other practice staff to keep them informed of any improvements to the dispensary service or changes to procedures. Minutes from a recent meeting of reception staff had not been recorded. We were told this meeting had included training for staff in relation to confidentiality. This information may also have been relevant to other staff groups but had not been shared. The lack of minutes for some meetings meant that the practice could not be assured that any issues raised had been actioned.

### Governance Arrangements

Quality and performance were monitored by the provider. The Quality and Outcomes Framework (QOF) was used to monitor the effectiveness of some aspects of the service, for example the number of unplanned hospital admissions and the identification of disease. Partner GPs had areas of responsibility, such as women's health, prescribing or safeguarding. Other GPs had areas of specialist interest, such as palliative care. The weekly clinical meetings were used for GPs to cascade information to colleagues. The GPs all felt they had a collective responsibility for making decisions and monitoring the effectiveness of clinical practice through audits or specialist training. The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing non-clinical staff whose roles were in reception or administration.

The practice manager and GPs demonstrated leadership in their governance arrangements as they used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality.

### Systems to monitor and improve quality & improvement (leadership)

We saw that incidents were reported promptly and analysed. We saw examples of learning from incidents and checks, and noted that where applicable, practices and protocols had been amended accordingly. There were systems in place to monitor quality and safety within the practice.

Clinical audits completed by the GPs to assess their effectiveness, these included those that were required to meet the QOF but also areas of interest or concerns as identified by individual GPs. Partner GPs had areas of responsibility, such as women's health, prescribing or safeguarding. Other GPs had areas of specialist interest, such as palliative care. The weekly clinical meetings were used for GPs to cascade information to colleagues. All audit results were discussed at clinical team meetings. This gave the GPs the opportunity to discuss and develop clinical practices in response to the outcomes of the audits. We were able to hear these discussions at the weekly meeting and the plan to complete the audit cycle by auditing again to check for change and improvement.

### Patient Experience & Involvement

The practice has a virtual patient participation group (PPG) this group has been established to gain feedback from patients about how the practice could make improvements. The practice had been actively trying to recruit members to the group in order to have a group that represented the practice population. The practice used an annual satisfaction survey to monitor the quality of the service and to be assured that patients remained satisfied with the care and treatment they received. All the patients we spoke with were complimentary of the staff at the practice and the service that patients had received. Patients told us that they felt involved in the decisions about their care and treatment. They were confident that they could discuss any areas of concern with the practice

# Are services well-led?

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

staff. A comments book was available in the reception area however this did not give patients a confidential way of raising any concerns or to make suggestions to the practice. The practice manager was aware of comments received from the GP Patient Survey about staff and the way in which they communicated with a patient. This information had been used for discussion and to address the concerns during staff appraisal.

### Practice seeks and acts on feedback from users, public and staff

Staff we spoke with told us they enjoyed working at the practice, most had been in their role for a number of years. The GPs we spoke with and the practice manager thought that the consistency of staff improved the service for their patients. Most of the staff we spoke with told us that they felt supported by their colleagues and the practice manager. Regular staff meetings were held which gave the opportunity to provide feedback about the service or to raise any concerns. However we found that the information from staff meetings was not always fed back to other staff groups.

We saw minutes of a recent staff meeting. These showed that everybody was given the opportunity to make comments or suggestions. There was evidence that relevant staff were involved in reviewing incidents in order to learn from them and minimise future risks.

### Management lead through learning & improvement

All staff had regular training and development opportunities. They told us that they were provided with paid time to attend relevant training courses for their role. Staff had annual appraisals to discuss areas in which they needed support in order to develop their knowledge and skills. These were linked to personal development plans with objectives for future learning. Training was also included as part of some staff meetings. The GPs and nurses at the practice had taken part in training to ensure they had the right skills to appropriately treat and support patients with certain long term conditions. The practice had one nurse specifically to provide care and support to patients with diabetes

### Identification & Management of Risk

There was evidence that the practice continually learnt from incidents and feedback. We saw examples of changes that had been made to procedures as a result of lessons learnt. For example changes had been made to dispensing practice following a prescribing error. The practice had a business continuity plan. However this did not include short term plans for the continued provision of patient care should the premises become unavailable. Risks related to the treatment of patients with infectious diseases had been assessed and a plan was in place to manage that risk.

# Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

## Our findings

Some staff had received training in safeguarding vulnerable adults although all staff were aware of their responsibilities in relation to reporting any concerns. The practice had a lead GP responsible for coordinating safeguarding issues.

We spoke with patients from this population group who told us that all staff treated them with dignity and respect. They did not feel rushed and by having continuity of care with the same GP felt that both their physical and emotional needs were being met. Patients described the compassionate support they had received when they were bereaved. The practice spoke to each bereaved family and offered to visit if necessary. The practice worked closely with the community nursing team and palliative care team to ensure the provision of end of life care.

An effective relationship had been established with a local day care service. There had been regular meetings between the GPs and the organisation to identify the best way to meet the medical needs of the patients.

There was a range of health education and information available throughout the practice to support patients in this population group. This included signposting to services that would improve their health and emotional well-being such as sport for older people, carer support and bereavement.

We saw that the practice responded to the needs of this population group by improving access to the services they needed. The practice carried out regular home visits for patients in this population group as access to transport in the semi-rural area was often difficult. The practice worked with a national charity to carry out patients' annual flu vaccinations at the day centre. The practice dispensary also delivered medicines to patients at home.

# People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

## Our findings

Patients who had long term conditions had their medicines reviewed and monitored. Nurses and GPs advised patients, and provided them with information, on the management of their long term condition and signposted them to relevant support organisations. Patients with long term conditions were encouraged to manage their own care as far as possible. Practice nurses provided support and met with specific patients to provide help and advice.

The GPs and nurses at the practice had taken part in training to ensure they had the right skills to appropriately treat and support patients with certain long term conditions. The practice had one nurse specifically to provide care and support to patients with diabetes.

The practice planned specialist services to meet the needs of patients with long term conditions. Patients were able to attend routine appointments to discuss their care and treatment and were not limited to specific days or times.

The practice had conducted a check of their dispensing services. As part of the check they had looked at how to improve the service for patients who required repeat prescriptions which is a characteristic of this population group. They had increased publicity about the ways or ordering repeat prescriptions and had established a number of options for the ease of patients.

# Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

## Our findings

The practice had a child immunisation programme. All vaccines, including those for the child immunisation programme, were held in a medicines fridge which was checked daily. We identified times when the fridge temperatures had gone outside the recommended range. At the time of the inspection the practice could not be sure that temperature sensitive medicines were safe and effective to use

Practice staff were aware of the contact details of the local authority safeguarding team and were clear that they would raise an alert if they felt a child was at risk of abuse. The GP who carried out the child vaccination clinics met with nurses and health visitors after the clinic. This gave them the opportunity to discuss any child protection issues or any concerns.

One of the partner GPs ensured that they carried out each baby's first immunisation to ensure that parents were aware of the risks and benefits and knew what they were consenting to.

A female GP partner had the lead role of women's health, who provided support and direction for other staff for this population group. Specialist training and information from study days was discussed at weekly clinical meetings. For example obstetric medicine and guidelines relating to prescribing the contraceptive pill were discussed at a clinical meeting on the day of our inspection. Patients we spoke with told us that there were good links between the GPs, midwives and health visiting team.

Reception staff told us that any child who was unwell would be seen by a GP the same day. One of the patients we spoke with from this population group told us that they felt the practice prioritised their appointments very well.

The practice operated a drop in for mothers, babies and young children. They were able to get advice from GPs and health visitors. Patients we spoke with felt that there were good links and communication between GPs and Health Visitors.

# Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

## Our findings

At times of unexpected GP absence there were systems in place to ensure that patients with booked appointments could be seen by another GP. This allowed the service to continue without disruption to patient care. Cancelled appointments may have been particularly inconvenient to patients with work commitments.

The practice had a range of health promotion leaflets in their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations. Well person health checks were made available for patients.

The practice had a Saturday morning surgery each week. This increased the accessibility of their service to people who were unable to attend during the day due to work commitments. This had been decided as the most beneficial time for working people as the practice was situated in an area popular with people commuting to work in London. There was capacity within the appointment system for all patients to be seen the same day if necessary to avoid unnecessary delays in diagnosis and treatment.

# People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

## Our findings

The practice area covered a community of travelling people and the practice had a small number of patients who had a learning disability. All the staff were aware of the practice population. They had identified patients who may find access to care difficult through their particular circumstances.

We heard reception staff speaking with a carer for a person with learning difficulties. Reception staff first checked their records to be sure there was a best interest decision in place to allow the carer to discuss the patient's details.

Children from all vulnerable groups were encouraged to take up child immunisations. There was a system in place to identify patients with a learning disability and staff ensured that these patients received an annual health check.

The reception staff told us that the practice was able to see anybody who came to the surgery and requested a GP appointment as a temporary patient although there was a specific geographical area that the practice covered. The practice had no special measures in place for patients in this population group but told us that the applied the same principles they used to provide safe effective care to all their patients.

The practice had actively sought the views of this minority group. They had through their patient feedback asked specifically for members of the local travelling community for their representation in the patient participation group (PPG). However at the time of our inspection this had not been possible.

# People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

## Our findings

The practice referred patients experiencing poor mental health to the community mental health team (CMHT) if appropriate. One of the GPs we spoke with was able to provide cognitive behaviour therapy for their patients to avoid a long wait for treatment.

A representative from CMHT used a room in the practice to provide easy access for patients. The practice worked with local mental health services to ensure patients were well supported. A counsellor from a local support group worked at the surgery. The counsellor was able to see referrals from the GPs and patients were able to self-refer to use their service.

Staff we spoke with displayed a non-judgemental attitude towards their patients. We were told that all patients were treated with the same dignity and respect whatever their health needs. Staff were educated and informed about local support services and provided information to patients.

The practice appointment system offered an accessible service for patients experiencing varying mental health problems and for those who required flexibility.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>**The provider did not have an effective system to manage risk in relation to the cold chain for vaccines.**<br>**The practice's Standard Operating Procedures for the dispensing of medicines were not always followed.**<br>**People were not protected against the risks associated with the management of medicines by means of appropriate arrangements for the safe keeping and dispensing of medicines.**<br>Regulation 13 |