Dr GAM Burnett and Partners

Quality Report

Sonning Common Health Centre
Wood Lane
Sonning Common
Reading
RG4 9SW
Tel: 0118 972 2188
Website: www.sonningcommonhealthcentre.co.uk

Date of inspection visit: 8 July 2014
Date of publication: 28/10/2014

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.

Contents

Summary of findings

Overall summary

Dr GAM Burnett and Partners, also known as Sonning Common Health Centre, is located in purpose built premises in a semi-rural area. It provides primary medical services to just over 8500 registered patients. The practice dispenses prescriptions to approximately one third of its patients.

We visited the practice location at Sonning Common Health Centre, Wood Lane, Sonning Common, Reading, RG4 9SW.

We spoke with 11 patients and 14 staff during the inspection.This was the first inspection since registration.The announced inspection at Sonning Common Health Centre took place on 8 July 2014.

We found the provider was in breach of the regulation, Management of medicines.

The practice operated from premises that were clean and well maintained. Systems were in place to report and learn from incidents to improve patient safety. The policies and procedure used by the service for the management of medicines had been reviewed, but were not always followed. Prescription pads completed by hand were not stored securely which increased the risk of prescriptions being misappropriated. Repeat prescriptions were signed by a GP after collection by the patient. Assurances could not be provided that refrigerated and non-refrigerated medicines were stored within their recommended temperature ranges.

Staff told us if they suspected abuse in children or adults they would raise concerns with the GP. We found staff had received training in safeguarding children but not in safeguarding adults. Emergency procedures were in place to respond to medical emergencies.

Systems were in place to ensure evidence based practice including national and local guidelines were used and monitored through audits. The practice supported patients to adopt healthy lifestyles by facilitating exercise programmes such 'Health Walks', cycling club and a gardening project.

The practice nurses were developed in their roles. For example, the lead nurse for diabetes was an advanced nurse practitioner in diabetes education and provided support to patients with diabetes. All staff received regular appraisals.

The practice was caring and compassionate in its approach. We spoke with 11 patients. They were very positive about all aspects of the care they received. This was supported by the national GP survey results for this practice. We also observed staff were respectful in their interactions with patients in a way that preserved their dignity and confidentiality.

The practice understood the different needs of the population it served and had developed services to meet their needs. For example, late evening and fortnightly Saturday morning surgeries were offered. A complaints system was in place to investigate and take action where concerns were identified.

Staff described a supportive team environment to provide a patient centred service. Governance arrangements were in place that ensured patients needs were a priority. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively. However, a whistleblowing policy was not in place.

All the GPs mentioned the practice's focus on education. All staff had been appraised in the last year. Staff said they had mandatory training updates. For example, in infection control, child safeguarding and basic life support. However, a robust system for recording and monitoring all staff training needs was not in place. The practice were aware of this but had not yet addressed this issue.

The practice considered the needs of older people in all aspects of the delivery of the service. The GPs involved patients and family in discussions before completion of the do not attempt cardiopulmonary resuscitation form. GPs and nurses were aware of what action to take if they judged a patient lacked the mental capacity to give their consent and they acted appropriately.

The practice supported patients with long term conditions to manage their health, care and treatment.

Summary of findings

The practice nurses were trained and experienced in providing diabetes and asthma care to ensure patients with these long term conditions were regularly reviewed and supported to manage their conditions.

Specific services for mothers, babies, children and young people included weekly antenatal clinics, baby immunisation clinics and baby development clinics. Family planning clinics were offered in the evening to improve access for young people.

The practice had introduced fortnightly Saturday morning surgeries and a weekly late evening surgery for routine appointments, to accommodate the needs of working age people.

The patient participation group was running a campaign to promote a local carers group which highlighted the support carers needed in relation to their own health and well-being.

The practice was working towards the joint Oxfordshire dementia plan to increase awareness and improve identification of patients at risk of dementia.

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 operated a safe service to meet the needs of patients and staff. Improvements were required in relation to some aspects of the way the practice managed medicines. The policies and procedure used by the service for the management of medicines had been reviewed, but were not always followed. Medicines and prescription pads completed by hand were not stored securely. Repeat prescriptions were signed by a doctor after collection by the patient. This posed a risk that patients medication was continued for longer than intended. However, we were told the frequency of repeat prescribing requests was monitored and concerns escalated to the GP. Assurances could not be provided that refrigerated and non-refrigerated medicines were stored within their recommended temperature ranges.

Staff told us they would raise any concerns they had with the GP if they suspected abuse in children or adults. We found staff had received training in safeguarding children but not in safeguarding adults.

The practice operated from premises that were clean and well maintained. Systems were in place to report and learn from incidents to improve patient safety.

Emergency procedures were in place to respond to medical emergencies. The practice had considered health and safety measures to reduce the risks to patients and staff.

Are services effective?

The practice operated an effective service. Systems were in place to ensure evidence based practice including national and local guidelines were used and monitored through audits. The practice nurses were developed in their roles. For example, the lead nurse for diabetes was an advanced nurse practitioner in diabetes education and provided support to patients with diabetes. All staff received regular appraisals and were supported to undertake further training to develop their role.

The practice worked closely with other services. For example, the health visitors and district nurses to provide patient centred care. Health promotion for patients was a priority for the practice, demonstrated through a number of exercise initiatives offered by the practice.

Summary of findings

Are services caring?

The practice was caring and compassionate in its approach. We spoke with 11 patients, they were very positive about all aspects of the care they received. This was supported by the national GP survey results. Patients were involved in decisions about their care and treatment. Staff were aware of their responsibilities with regards to patient confidentiality and they sought consent before sharing information. GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. We observed staff were respectful in their interactions with patients and preserved their dignity.

Are services responsive to people's needs?

The practice was responsive to patients needs. The practice understood the different needs of the population it served and had developed services to meet their needs. For example, it operated a flexible appointment system which involved a duty GP, to ensure all patients who needed to be seen the same day were accommodated, including late evening and fortnightly Saturday morning surgeries. A weekly transport service, via a local voluntary group was funded by the practice. A dispensing service for patients who lived more than one mile from a pharmacy was provided.

Patients who had been referred for treatment to other services said they were satisfied with the speed and quality of referral. A private physiotherapy service was available for patients on site.

The practice had a system in place for handling complaints and concerns. Information for patients on the complaints procedure was available on the practice website and booklet. Two patients who told us they had made complaints in the past were both satisfied with the way the practice had responded to their

Are services well-led?

Staff were aware of their individual responsibilities and also described a supportive team environment to provide a patient centred service. Governance arrangements were in place to ensure staff were clear about their responsibilities and were familiar with practice procedures. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively. However, a whistleblowing policy was not in place.

The practice had systems in place to ensure actions were taken in a timely manner. For example, electronic colour coding to prioritise message alerts and a buddy system for GPs and nurses to cover duties while staff were on leave.

Summary of findings

The practice valued the role of their patient participation group (PPG). The PPG is a forum for patients of the practice to share their experience and engage in improving the service for all patients. One of the senior partners regularly attended the PPG meetings.

All the GPs mentioned the practice's focus on education. All staff had been appraised in the last year. Staff said they had mandatory training updates. For example, in infection control, child safeguarding and basic life support. However, a robust system for recording and monitoring all staff training needs was not in place. The practice was aware of this but had not yet addressed this issue.

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

Older people were a large part of the registered practice population. The practice considered the needs of older people in the provision of the service. The practice worked closely with a local nursing home to ensure patients received consistent care from a named GP. The GPs worked closely with the nursing home to improve the service. For example, they were developing a future planning document for nursing home patients to ensure their best interest and wishes were respected.

One of the GPs told us they involved patients and family in discussions before completion of the do not attempt cardiopulmonary resuscitation form. GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed.

GPs described the integrated stroke patient pathway which required close working across a number of healthcare professionals. However, we were told this could be difficult to coordinate due to the funding arrangements in different localities and this could lead to interruptions in the rehabilitation programme of patients who had suffered a stroke.

People with long-term conditions

Patients with long term conditions were part of the general practice population and often older people. The service supported patients with long term conditions to manage their health, care and treatment. All patients had a named GP and this was particularly welcomed by patients with long term conditions to facilitate continuity of care.

The practice monitored the prevalence of long term conditions across the practice population in line with best evidence based practice. The practice achieved 99.5% of the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The practice nurses were trained and experienced in providing diabetes and asthma care, to ensure patients with these long term conditions were regularly reviewed and supported to manage their conditions. Regular searches were carried out of the registers of patients with long term conditions. This identified patients who had

Summary of findings

not attended for regular reviews and they were sent recall appointments. GPs followed the relevant National Institute for Health and Care Excellence (NICE) guidelines for long term conditions management.

The practice provided specific medication to patients at the end of life in advance of when they may need it. This was to avoid undue distress to patients and relatives by reducing delays in obtaining medicines out of hours.

Mothers, babies, children and young people

Specific services for this group of patients included regular weekly antenatal, baby immunisations and baby development clinics. Family planning clinics were offered in the evening to improve access for young people. Antenatal clinics were provided on site by the visiting midwife attached to the practice. Baby clinics were managed by the attached health visitors.

The practice had a close working relationship with the co-located health visitors, which enabled them to raise concerns promptly when they arose.

The working-age population and those recently retired

The practice had introduced fortnightly Saturday morning surgeries and a weekly late evening surgery for routine appointment to accommodate the needs of the working age people. The practice also offered the convenience of a daily phlebotomy service, well woman clinic, minor conditions managements and travel immunisations. Online repeat prescription and appointment bookings were also available. Health promotion initiatives including 'Healthwalks', 'Green Gym' (gardening project) and cycling clubs which were all aimed at adults to maintain healthy lifestyles.

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

The patient participation group was running a campaign to promote a local carers group which highlighted the support carers needed in relation to their own health and well-being.

A follow up of bereaved patients was offered one year after their bereavement to assess their needs.

The patient participation group was running a campaign to promote a local carers group which highlighted the support carers needed in relation to their own health and well-being.

A prescription delivery service was offered for vulnerable patients to ensure they obtained their medicines when needed.

Summary of findings

Patients with learning disabilities were offered an annual health check in line with national guidance.	
People experiencing poor mental health The practice was working towards the joint Oxfordshire dementia plan to increase awareness and improve identification of patients at risk of dementia. GPs worked with the community mental health team to reduce the demand for antipsychotic medication for patients in nursing homes. Counselling services, private and NHS were provided on site.	

Summary of findings

What people who use the service say

What people who use the service say

We spoke with 11 patients during the inspection and received two comment cards. We also spoke to a representative of the patient participation group (PPG). All the patients we spoke with were extremely positive about the service they received.

Sonning Common Health Centre results for the national GP survey, July 2014, were better in all areas compared to the clinical commissioning group (CCG) and national average. The results of the PPG survey 2014 indicated patients were very positive about the care they received. The few negative comments were in relation to contacting the practice and the car park facilities.

Areas for improvement

Action the service MUST take to improve

- The practice should ensure repeat prescriptions generated are signed by a GP before dispensing and collection by the patient.

Action the service SHOULD take to improve

- The practice should formalise arrangements to deal with staff concerns to include a whistle blowing policy.
- Whilst the practice had a learning culture they should put a system in place to record and monitor all staff training.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

- The health promotion initiatives led by the practice to encourage patients to adopt healthy lifestyles, including 'Health Walks', 'Green Gym' (gardening and conservation project) and cycling club. 'Health Walks' had been pioneered by a founding partner of the practice and had developed nationally and internationally; it was now a well-known scheme, similarly the Green Gym. The practice focus on encouraging and actively supporting patients to adopt exercise had continued with other initiatives including a cycling club led by the Senior GP Partner. The practice is one of the sponsors of an annual local cycling event which attracted over 500 riders this year.
- The practice followed the Gold Standards Framework for end of life care. The Gold Standards Framework is a systematic evidence based approach. It is designed to assist healthcare professionals to optimise care for all patients approaching the end of life.

Dr GAM Burnett and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP. The team included an additional CQC inspector, a CQC pharmacist inspector and a specialist in practice management.

Background to Dr GAM Burnett and Partners

Dr GAM Burnett, also known as Sonning Common Health Centre, is located in purpose built premises in a semi-rural area. It provides primary medical services to just over 8500 registered patients. The practice has four GP partners, four associate GPs and four GP trainees, practice nurses, administration, reception staff, dispensary staff and two practice managers; a total of 34 staff. The practice dispenses prescriptions to approximately a third of its patients. The practice has a higher proportion of patients over the age of 45 years compared to the local Oxfordshire Clinical Commissioning Group (CCG) and national average and a lower proportion in the 20-39 year age group. The practice serves a population which is more affluent than the national average. The practice has been accredited to provide training to GP trainees.

The practice has opted out of providing Out-of Hours services to its own patients and uses the services of a local Out-of-Hours service.

Why we carried out this inspection

We inspected this service 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

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Prior to the inspection we contacted the local clinical commissioning group, NHS England area team and local

Detailed findings

Healthwatch to seek their feedback about the service provided by Sonning Common Health Centre. We also spent time reviewing information that we hold about this practice.

We carried out an announced visit on 8 July 2014.

We spoke with 11 patients and 14 staff. We also reviewed two comment cards from patients, staff and members of the public who shared their views and experiences.

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff cared for patients and talked with them. We interviewed a range of staff including the senior GP partner, GPs and GP trainees, members of the practice management team, nursing, reception, administration and secretarial staff.

Are services safe?

Our findings

Safe Track Record

The practice had implemented systems for reporting and responding to incidents. We reviewed 20 significant event analysis (SEA) reports that had been identified and recorded in the previous 12 months. We found they had been completed by the majority of GPs on a range of incidents including prescribing, clinical decision making and poor communication with other providers. The reports included actions that had been taken in response to the incidents to reduce future recurrence and improve patient safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The SEA reports referred to above included changes to practice procedures, or staff retraining, to avoid recurrence of the incidents and lessons learned. These had been discussed by the whole practice team and discussions recorded in the notes of the serious event meetings. Staff we spoke with recalled recent incidents they had reported and the subsequent change in practice, if appropriate.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP partner was the practice lead for safeguarding children. Safeguarding policies and procedures consistent with the local clinical commissioning group (CCG) and Local Authority guidelines were in place to protect children and vulnerable adults. The practice child protection lead had carried out Royal College of General Practice audits on child protection in 2013 and 2014. These indicated the practice was compliant in most areas and the latter audit demonstrated an improvement from one year to the next as a result of actions taken.

Safeguarding information, including local authority contacts, were on display in the treatment rooms for ease of access by staff. Staff demonstrated an understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. All staff had received training in safeguarding children. However, we found there was a lack of staff training in safeguarding adults and no named lead for safeguarding vulnerable adults.

Monitoring Safety & Responding to Risk

The practice had considered the risks of delivering the service to patients and staff and had implemented systems to reduce risks. We observed the practice was organised and tidy. We reviewed the practice fire risk assessment and noted safety equipment such as fire extinguishers were checked and sited appropriately.

Medicines Management

The practice had policies and procedures for their staff covering the supply of medicines. We found these were not being monitored to ensure staff were following the procedures consistently The practice had appropriate medicines refrigerators which they monitored the temperatures of on a daily basis. However, we saw from the recordings for two of the refrigerators there were occasions when their temperatures were outside of the range recommended by manufacturers for some medicines. The practice had not taken any action in response and did not seem to be aware of the refrigerators being outside of the temperature range.

Some repeat prescriptions were generated by practice staff. These were not signed by a doctor until after they had been dispensed and collected by the patient from the dispensary.

Cleanliness & Infection Control

Systems were in place to reduce the risks of spread of infection. A designated member of staff was the practice infection control lead person. They demonstrated a good understanding of their role. All staff had received training in infection control and were aware of infection control practices. For example, we observed staff used personal protective equipment such as gloves and saw that they disposed of clinical waste safely. Reception staff were aware of how to handle specimens from patients and that only clinical staff were permitted to clean spillages of blood or other body fluids.

In June 2014 the practice had commissioned an external contractor to assure itself of compliance in infection prevention and control. We reviewed the results of the infection control audit carried out in June 2014. It highlighted a number of areas that had been identified for improvement. A Legionella risk assessment had been carried out and further actions were part of the practice action plan.

Are services safe?

All the patients we spoke with said they had never had any concerns regarding the standard of cleanliness at the practice. We observed all areas of the practice were clean and well maintained. Daily cleaning schedules were followed and monitored. The practice had ensured they met the requirements outlined in the Department of Health Code of Practice on the Prevention and Control of Infections and Related Guidance 2010.

Staffing & Recruitment

The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and available for annual leave and sickness absence cover. A bank of regular GP locums was used to ensure familiarity with practice procedures and a degree of continuity of care for patients.

There were recruitment and selection processes in place. Staff described the recruitment process which followed best practice guidelines. We reviewed a sample of five files which confirmed the required pre-employment information had been sought. These all included most of the required information including a curriculum vitae or application form, one or two references, occupational health check, photographic identity and professional registration check. We saw the practice had undertaken a risk assessment for Disclosure and Barring Service checks for reception and administrative staff and determined the risk was minimal. We found the practice policy on checking of hepatitis B immunity was not clear. Up to date records of staff hepatitis B immunity status were not available, this potentially posed a risk to staff of occupational exposure to this infection.

Dealing with Emergencies

The practice had a service continuity plan in place in case of emergency. Relevant contact numbers for staff and resources were recorded in the plan. These were to be used in the event of an incident that effected the operation of the service to ensure, where possible, alternative provision could be made and patients were appropriately informed.

Equipment

A log of all practice equipment was in place. Regular service and calibration checks on equipment were performed. This ensured equipment was safe to use. Panic alarms were installed in all consulting and treatment rooms in case of emergency. All staff would respond if a call was raised.

Medical equipment, including medicines, a defibrillator and oxygen were available for use in the event of a medical emergency. The equipment and medicines were checked daily to ensure it was in working condition. All staff had training in basic life support and defibrillator training to enable them to respond appropriately in an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured they kept up to date with new guidance, legislation and regulations. GP trainees were expected to present the evidence to their GP trainer to support their clinical decisions. This resulted in a culture of learning and constructive challenge where clinical decisions were considered in the light of best practice and experience.

The practice achieved 99.5% of the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice maintained and managed patients with a range of long term conditions in line with best evidence based practice.

Sonning Common Health Centre fully participated in all the prescribing audits in the local prescribing incentive scheme 2013/14. It achieved all three areas of the scheme including a reduction in
antimicrobial prescribing.

Management, monitoring and improving outcomes for people

Daily clinical meetings were held where GP trainees and trainers discussed issues and agreed a course of action for individual patients, based on sound evidence such as recognised national or local guidance. The practice had a clinical audit plan in place. We reviewed a sample of five clinical audits, two of which were re-audits. We found not all planned re-audits had been completed to confirm changes had been implemented. However, there was clear evidence of a focus on completing the audit cycle. We found regular audits of the family planning service were carried out to maintain standards.

Effective staffing, equipment and facilities

New staff followed an induction programme and probationary period, followed by a formal review. This ensured staff were familiar with practice procedures and competent to perform their duties. The practice nurses were developed in their roles. For example, the lead nurse for diabetes was an advanced nurse practitioner in diabetes education. All staff received regular appraisals and were supported to undertake further training to develop their role.

Regular checks on the premises and equipment were in place to ensure they were fit to use. For example, service checks on gas, electricity and fire equipment were all up to date.

Working with other services

Multi-disciplinary meetings which included members of the palliative care team and community nursing team were held every two weeks. Discussion of palliative care patients followed the Gold Standards Framework for end of life care. The Gold Standards Framework is a systematic evidence based approach. It is designed to assist healthcare professionals to optimise care for all patients approaching the end of life.

We spoke with community nurses and health visitors who occupied offices in the practice. They were very positive about how the practice fostered close working relationships and were inclusive in their approach. For example, they told us they were invited to the practice training events and included in the induction programme for GP trainees.

GPs described the integrated stroke patient pathway which required close working across a number of healthcare professionals. However, we were told this could be difficult to coordinate due to the funding arrangements in different localities and this could lead to interruptions in the rehabilitation programme of patients who had suffered a stroke.

The practice operated a GP buddy system which ensured all correspondence and results were managed in a timely manner to optimise patient care. The GP buddy system ensured all essential duties, for example, checking test results and signing prescriptions were completed when a GP was on leave.

Health Promotion & Prevention

All newly registered patients were offered a consultation which included health promotion advice.

A range of information was available in the reception area and on the practice website, aimed at patients for health promotion and self-care. A detailed practice booklet which described a number of health promotion initiatives

Are services effective?

(for example, treatment is effective)

including 'Health Walks', 'Green Gym' (gardening and conservation project) and cycling club. 'Health Walks' had been pioneered by a founding partner of the practice and had developed nationally and internationally. It was now a well-known scheme, similarly the Green Gym. The practice focus on encouraging and actively supporting patients to adopt exercise had continued with other initiatives including a cycling club led by the Senior GP Partner. The practice is one of the sponsors of an annual local cycling event which attracted over 500 riders this year.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 11 patients during the inspection and received two comment cards. The 11 patients consisted of three older patients, five retired patients with long term conditions and three younger working age patients. Nine of the patients had been with the practice more than 10 years. We also spoke with a representative of the patient participation group (PPG). All the patients we spoke with were extremely positive about all aspects of the service they received.

GPs and staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard. Staff respected patients and preserved their dignity and privacy. Privacy curtains were in place in every consultation room.

During the inspection we witnessed numerous caring and compassionate interactions between all staff and patients.

An example of the compassionate nature of the practice was in relation to bereaved relatives. In this situation the usual GP contacted the family to offer support. An annual reminder was also sent to staff to ensure appropriate sensitivity if a relative attended the practice around the time of the anniversary of the bereavement.

Involvement in decisions and consent

Patients told us they had enough time during consultations to ask questions and be involved in decisions regarding their care and treatment.

Patients preferred methods of communication was recorded and the practice sought the patients consent before messages were left on answerphones.

GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed. One of the GPs told us they involved patients and families in discussions before completion of the do not attempt cardiopulmonary resuscitation form.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to patients needs

The practice had developed its services to meet the needs of its registered practice population. For example, a family planning clinic was available in the evenings to accommodate the needs of young people.

The practice provided specific medicines to patients at the end of life in advance of when they may need them. This was to avoid undue distress to patients and relatives by reducing delays in obtaining medicines out of hours.

Sonning Common Health Centre results for the national GP survey, July 2014 were better in all areas compared to the local clinical commissioning group (CCG) and national average. The results of the patient participation group (PPG) survey 2014 indicated patients were very positive about the care they received. The few negative comments were in relation to contacting the practice and the car park facilities. An action plan to address the issues raised in the questionnaire had been developed although clear deadlines had not been set for when actions were to be completed by.

Access to the service

The practice operated a flexible appointment system which involved a duty GP, to ensure all patients who needed to be seen the same day were accommodated. A weekly transport service, via a local voluntary group was funded by the practice. This was available for patients resident in a nearby village, without their own transport for routine appointments, which the practice scheduled on Friday mornings. The practice had introduced one late evening surgery per week and fortnightly Saturday morning surgeries to improve access. Annual flu clinics were scheduled on Saturdays to increase the attendance of patients who were eligible for the flu vaccination. The practice offered a dispensing service for patients who lived more than one mile from a pharmacy and a repeat request drop off point at a nearby village post office for patients who did not use the online service.

Meeting people's needs

Patients who had been referred for treatment to other services said they were satisfied with the speed and quality of referral. The practice was in the process of developing care plans for patients with complex needs. For example, patients on multiple disease registers. The named GP was responsible for producing and reviewing the care plan to meet patient needs.

A private physiotherapy service was offered to patients on site.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Complaints information was made available to patients in the practice leaflet and on the practice website. Most patients we spoke with said they had never had cause to complain. Two patients who had complained both said their concerns had been responded to, to their satisfaction.

We reviewed the practice complaints log. We found there had been six complaints between 2012-2014. The practice had investigated all the complaints and implemented actions and shared learning at the serious event meetings. The complaints had been investigated and lessons learned.

Are services well-led?

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

Our findings

Leadership & Culture

All staff spoke about a desire to provide high quality, patient centred care. The practice benefited from dedicated long serving staff. Staff described a supportive and inclusive environment where individual roles were valued. The GPs in the practice emphasised a strong focus on education and learning for all staff and for patients to be supported to adopt healthy lifestyles.

Governance Arrangements

Arrangements were in place to ensure staff were clear about their responsibilities and were familiar with practice procedures. An annual practice meeting schedule was in place which covered administration meetings, clinical meetings and business meetings. The meetings supported staff and ensured they were kept up to date with changes to practice systems. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively.

Every morning a clinical meeting was held which GPs and nurses told us they found very valuable in discussing day to day clinical issues and obtaining support from colleagues.

The practice had a system to ensure actions were taken in a timely manner. For example, a colour coded message alert system was used so that GPs could easily prioritise messages during busy clinics. The practice operated a buddy system for GPs and nurses to ensure suitable cover was provided when their buddy colleague was on leave. This included checking correspondence and test results. Unchecked test results were highlighted on the screen and could only be closed when a GP had reviewed the result and recorded the action to be taken.

Systems to monitor and improve quality & improvement

The practice achieved the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the quality and productivity domain. The practice reviewed its data on emergency admissions and accident and emergency (A&E) attendance, participated in external peer review and implemented a plan to reduce avoidable A&E attendance.

Patient Experience & Involvement

The practice valued the role of their patient participation group (PPG) and meetings were attended by one of the GP partners. The PPG is a forum for patients of the practice to share their experience and engage in improving the service for all patients. The Sonning Common Health Centre PPG consisted of 25 members. They were all patients of the practice and were actively involved in the practice. The PPG was made up of mainly older patients. However, they were active in trying to recruit younger and working age patients. They scheduled evening meetings to encourage attendance of these groups. This was supplemented by an extended virtual group forum. We reviewed the PPG report 2013/14 following the PPG survey. We were told the survey response was significantly higher than in previous years due to the wide dissemination of the surveys and the option of paper and online completion. The majority of feedback was positive. Suggestions included improvements for patients when contacting the practice. An action plan had been developed, although clear deadlines had not been set for when actions were to be completed by.

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

Staff told us they felt valued as part of the practice team. There were opportunities for formal and informal communication for staff, to ensure issues were raised and managed appropriately. An annual meeting schedule was in place which included significant event meetings, clinical meetings and practice business meetings. The practice nominated a senior partner who was the designated lead for staff matters and formally responsible for dealing with staff concerns or issues. We spoke with staff about whistleblowing. One GP, nurse and receptionist were not aware if the practice had a whistleblowing policy in place or the formal procedure to be followed if they suspected wrongdoing at work. The practice welcomed feedback from the public, via a contact form on the practice website, a suggestion box in the reception area and the NHS choices website.

Management lead through learning & improvement

All the GPs mentioned the practice's focus on education. GP trainees were expected to present an evidence base to support treatment and referral decisions to their GP trainer. Staff said they had opportunities for development. All staff had been appraised in the last year. Staff told us they felt the appraisal was a meaningful process and identified areas for future personal development. Staff said they had mandatory training updates. For example, in infection

Are services well-led?

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

control, child safeguarding and basic life support. However, a robust system for recording and monitoring all staff training needs was not in place. The practice were aware of this but had not yet addressed this issue.

Identification & Management of Risk

The practice had carried out a range of risk assessments reviewing environmental and personal risks, to ensure the health and safety of patients, visitors and staff members. The practice had a service continuity plan in place in case of emergency. Relevant contact numbers for staff and resources were recorded in the plan. These were to be used in the event of an incident that effected the operation of the service to ensure, where possible, alternative provision could be made and patients were appropriately informed.

The practice regularly reviewed its policies and procedures and implemented changes as a result of learning from serious events.

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

Older people were a large part of the registered practice population. The practice considered the needs of older people in the provision of the service. The practice worked closely with a local nursing home to ensure patients received consistent care from a named GP. The GPs worked closely with the nursing home to improve the service. For example, they were developing a future planning document for nursing home patients to ensure their best interest and wishes were respected.

One of the GPs told us they involved patients and family in discussions before completion of the do not attempt cardiopulmonary resuscitation form. GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed.

GPs described the integrated stroke patient pathway which required close working across a number of healthcare professionals. However, we were told this could be difficult to coordinate due to the funding arrangements in different localities and this could lead to interruptions in the rehabilitation programme of patients who had suffered a stroke.

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 with long term conditions were part of the general practice population and often older people. The service supported patients with long term conditions to manage their health, care and treatment. All patients had a named GP and this was particularly welcomed by patients with long term conditions to facilitate continuity of care.

The practice monitored the prevalence of long term conditions across the practice population in line with best evidence based practice. The practice achieved 99.5% of the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The practice nurses were trained and experienced in providing diabetes and asthma care, to ensure patients with these long term conditions were regularly reviewed and supported to manage their conditions. Regular searches were carried out of the registers of patients with long term conditions. This identified patients who had not attended for regular reviews and they were sent recall appointments. GPs followed the relevant National Institute for Health and Care Excellence (NICE) guidelines for long term conditions management.

The practice provided specific medication to patients at the end of life in advance of when they may need it. This was to avoid undue distress to patients and relatives by reducing delays in obtaining medicines out of hours.

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

Specific services for this group of patients included regular weekly antenatal, baby immunisations and baby development clinics. Family planning clinics were offered in the evening to improve access for young people. Antenatal clinics were provided on site by the visiting midwife attached to the practice. Baby clinics were managed by the attached health visitors.

The practice had a close working relationship with the co-located health visitors, which enabled them to raise concerns promptly when they arose.

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

The practice had introduced fortnightly Saturday morning surgeries and a weekly late evening surgery for routine appointment to accommodate the needs of the working age people. The practice also offered the convenience of a daily phlebotomy service, well woman clinic, minor conditions managements and travel immunisations. Online repeat prescription and appointment bookings were also available. Health promotion initiatives including 'Healthwalks', 'Green Gym' (gardening project) and cycling clubs which were all aimed at adults to maintain healthy lifestyles.

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 patient participation group was running a campaign to promote a local carers group which highlighted the support carers needed in relation to their own health and well-being.

A follow up of bereaved patients was offered one year after their bereavement to assess their needs.

The patient participation group was running a campaign to promote a local carers group which highlighted the support carers needed in relation to their own health and well-being.

A prescription delivery service was offered for vulnerable patients to ensure they obtained their medicines when needed.

Patients with learning disabilities were offered an annual health check in line with national guidance.

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 was working towards the joint Oxfordshire dementia plan to increase awareness and improve identification of patients at risk of dementia. GPs worked with the community mental health team to reduce the demand for antipsychotic medication for patients in nursing homes.

Counselling services, private and NHS were provided on site.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered provider did not protect people against the risks associated with the unsafe use and management of medicines because appropriate arrangements were not in place for the safekeeping of medicines (Regulation 13)**