

Dr M L Swami & Partners

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall.

At our previous inspection in June 2016 the practice had an overall rating as Good.

Following the November 2017 inspection, the key questions are rated as:

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

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

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

We carried out an announced comprehensive inspection at Dr M L Swami and Partners in Reading, Berkshire on 21 November 2017. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether Dr M L Swami and Partners was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen and any notable events either positive or negative were learned from.
- The practice had defined and embedded systems, processes and practices to minimise risks to patient safety.
- However, we found these systems had not identified risks related to the ongoing monitoring of patients on medicines where care was shared with other health services. There were also risks identified related to actions following test results or other patient related information received into the practice.
- Staff had received training appropriate to their roles and the population the practice served. Any further training needs had been identified and planned.
- Our findings showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.

Summary of findings

- Clinical outcomes in national data submissions showed high performance for managing patients with long term conditions.
- We received positive feedback from patients and external stakeholders which access GP services from the practice.
- Patients found the appointment system easy to use.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. For example, telephone access had been a historic concern within the practice. As a result, the practice reviewed the telephone system and increased staff who answered calls.
- The practice had clear and visible clinical and managerial leadership and supporting governance arrangements.

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

- Ensure risks to patients are identified, assessed and mitigated to protect patients' health and welfare.

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

- Review the potential requirements of patients with limited mobility and access to services to patients who may need additional support, with regard to the legal requirements of the Disability Discrimination Act (1995) and Equality Act (2010).
- Undertake a full review of the requirements of the accessible information standard.

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

Dr M L Swami & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector. The team included a GP specialist adviser.

Background to Dr M L Swami & Partners

Dr M L Swami & Partners, provides services to 7,990 patients from three sites:

- Russell Street Surgery, Russell Street, Reading, RG1 7XG.
- Coley Park Surgery, Wensley Road, Reading, RG1 6DN.
- Burghfield Health centre, Reading Road, Burghfield Common, Reading, RG7 3YJ.

This inspection was carried out at the Russell Street Surgery which is based in a converted residential dwelling. We also visited Coley Park Surgery as part of the inspection.

The practice population is younger than the national average, made up of a higher proportion of young children

and also adults under 44 years whilst the proportion of over 60 year olds is much lower. The 2011 census shows that 30.5% of the resident population of South Reading is from a Black and Minority Ethnic (BME) group. An additional 10.6% are from a White non-British background with 29.5% of the resident population born outside of the UK and 6.7% resident in the UK for less than two years. Over the last two years the practice population has increased by 1,500 patients.

The practice has four full-time GP partners, including two females and two males. The practice has two practice female nurses. The GPs and the nursing staff are supported by a team of administration staff who carry out, reception, and other support roles. There is a practice manager in post. The practice opens between 8.00am and 6.30pm on Monday, Tuesday, Wednesday and Friday and between 8.00am and 2.00pm Thursday. Early and later appointments are available in addition to Saturday appointments.

The practice has opted out of providing out-of-hours (OOHs) services to their own patients and refers them to the GP OOHs provider, Westcall, via the NHS 111 service.

Are services safe?

Our findings

We rated the practice as requires improvement for providing safe services.

The practice was rated as requires improvement for providing safe services because:

- There was not a process or system to ensure that patients on high risk medicines were monitored by the practice appropriately.
- The system used to monitor follow up actions after test results and correspondence was not adequate. The practice was not ensuring that where patients required follow up care that this was always taking place.

Safety systems and processes

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

- The practice conducted safety risk assessments. We saw examples of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. All staff received up-to-date safeguarding and safety training appropriate to their role in order to identify and respond appropriately to suspected abuse. Partners informed us there was also additional training specific to the needs of the local community. For example, they informed us there was Female Genital Mutilation (FGM) awareness training.
- The practice carried out relevant staff checks. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We saw staff had proof of identification, employment histories, references and proof of Hepatitis B immunisation on record.

- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control including yearly infection prevention control audits. The most recent was undertaken in November 2017 and showed high levels of compliance with infection control standards. We found the premises to be clean and tidy at both sites visited. Staff had an awareness of infection control relevant to their role. For example, reception staff had a process to follow for handling samples.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. This included annual calibration of medical equipment and monthly calibration of spirometry equipment (spirometry is used in the assessment of respiratory conditions).

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Training records indicated that staff were provided with an understanding of how to manage emergencies on the premises. There were procedures for medical and other emergencies which may occur.
- There were various assessment tools for medical conditions which may require urgent attention. However, the practice was not using any assessment tool for sepsis as recommended by national guidance (sepsis is an infection with significant exacerbations which can lead to serious illness or death). The practice implemented a tool immediately following the inspection.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients. However, the systems in place to ensure information was always acted on were not adequate.

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- There was a log for recording any follow up action required when test results were received. This log was used when a GP asked a member of the support team to request a patient to book an appointment or undertaken other action. The log was not monitored properly to ensure that patients responded appropriately when contacted. For example, a non-urgent test result for a patient led to a request being placed in the log to action on 7 August 2017. On the day of inspection nothing was recorded in the patients' notes or on the log to demonstrate the patient had attended for an appointment or further tests. GPs explained that any urgent action would be dealt with at the time of reviewing test results, such as requesting an appointment or phoning a patient and the log was for routine follow up actions. However, the lack of a coherent system for ensuring actions were completed following test results posed a risk to patients.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Care plans for elderly patients were stored on a system accessible to external services such as paramedics.
- Patient correspondence from external clinicians and services was disseminated to the relevant patients' GPs. We saw that this information was dealt with quickly. However, paper correspondence was not scanned onto the system to ensure that if the paper record was mislaid, an electronic copy would be available and stored on a patient's electronic records.
- Referral documentation was dealt with in a timely way.
- 82% of Patients on more than four medicines had up to date medicine reviews and 71% of patients on less than four repeat medicines had up to date reviews.
- Medicines were not always prescribed safely. There was not adequate monitoring where patients were subject to shared care arrangements for the initiation or ongoing treatment of conditions. We reviewed the prescribing of medicines such as methotrexate, lithium or warfarin, we saw evidence the practice sometimes relied on secondary care services to monitor the safe prescribing of these medicines. We saw examples where the practice had prescribed these medicines without the appropriate blood tests or other monitoring in place, as they had relied on the hospital care teams to do so. There was no process at the practice to assure prescribers that external services were monitoring these patients appropriately. The practice informed us that the day after the inspection the practice decided to place all high risk medicines on one monthly prescriptions to enable a review process to begin on all of these patients.
- We saw patient literature in the waiting areas which clearly explained safe and appropriate antibiotic usage.
- Medicines were administered by non-prescribing nurses with the appropriate authorisation and monitoring from GPs.

Track record on safety

The practice had a good safety record.

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

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines. However, we identified risks with the system for prescribing of high risk medicines.

- The systems for managing medicines, including vaccines, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.

Are services safe?

- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, we reviewed an event where a patient was prescribed the wrong dosage of medicine following a diagnosis of a long term condition. This was identified by an external professional and the practice amended the prescription and monitored the patient to ensure the new prescription had the appropriate therapeutic effect.
- There was a significant event monitoring log which indicated what action was taken in response to each event. Investigation outcomes were shared with relevant staff.
- We reviewed medicine and other safety alerts and found they were recorded, and shared with relevant staff. We saw alerts were then discussed at meetings.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

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

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

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

- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group was 0.23. This was better when compared national average (0.98). Hypnotics, more commonly known as sleeping pills, are a class of psychoactive drugs whose primary function is to induce sleep and to be used in the treatment of insomnia, or surgical anaesthesia. Hypnotics should be used in the lowest dose possible, for the shortest duration possible and in strict accordance with their licensed indications.
- The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 1.12. This was similar when compared to the national average (1.01). Furthermore, the number of antibiotic items (Cephalosporins or Quinolones) prescribed was better (2%) when compared to local (4.48%) and national averages (4.71%). The practice demonstrated awareness to help prevent the development of current and future bacterial resistance. Clinical staff and prescribing data evidenced the practice prescribed antibiotics according to the principles of antimicrobial stewardship, such as

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

Older people:

- The practice provided GP services to a local nursing home. Patients who are in care homes received a care plan within eight weeks of arrival, receiving a face to face review with the GP responsible for their care. Anticipatory care plans were provided which included identifying patients who were frail. The practice informed us these patients had a face-to-face review.
- Patients aged over 75 were invited for a health check. This included a medication review, annual chronic disease check, blood tests and immunisations if required. The practice undertook annual dementia reviews to identify new diagnoses. There were two so far in 2017. Out of 20 patients on the register 19 had dementia care plans already in place for the year 2017/18.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- The number of patients registered at Dr M L Swami and Partners with a long-standing health condition was 52%. This was higher when compared to the local CCG average (44%) and similar to the national average (53%). A high prevalence of long-standing health conditions can increase demand on GP services.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, the nurse who ran a specialist diabetes clinic had received additional training to initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.

Are services effective?

(for example, treatment is effective)

- Performance for diabetes related indicators showed the practice had achieved 98% of targets which was better when compared to the CCG average (90%) and the national average (91%). A diabetic virtual clinic was held every quarter with a consultant endocrinologist from a local hospital to discuss patients whose diabetes is poorly controlled.
- The practice had identified the number of its patients exempted from long term condition review and care indicators in line with national guidance as a concern in recent years. As a result the practice had reduced exception reporting to 5.6% and was significantly below national average of 10%.

Families, children and young people:

- Childhood immunisation rates for the vaccinations given were lower when compared to the national averages. For children under two years of age, four immunisations have performance measured per GP practice; each has a target of 90%. The practice missed the 90% target by 3% for two indicators and 2% for another. The indicator for the pneumococcal conjugate booster was missed by 10%. The practice was above average by 5% for vaccines provided to patients under five years old for MMR dose one and under average by 6%. The practice was aware of this and provided explanations that there were irregularities in the recording of immunisations in the local area. In the previous years, before the introduction of the immunisation recording system, immunisation rates were higher than local and national averages. Immunisation data for children aged five, was similar when compared to local and national averages.

•The practice had arrangements to identify and review the treatment of newly pregnant women.

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

- The practice's uptake for cervical screening was 87%, which was higher when compared to the national average (81%). Patients who did not attend for screening were followed up by the practice. Alongside opportunistic screening and a recall system in place with first and second letter reminders sent directly to patients in various languages including Urdu and Hindi.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged

40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. There had been 38 assessments in the last year.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- There were 50 patients on the Learning Disabilities register and 37 of which were over 14 years old and all had an annual health check in the last year.

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

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher when compared to the local average (86%) and the national average (84%).
- 99% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher when compared to the local CCG average (93%) and national average (90%).

Monitoring care and treatment

The practice reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. For example, there were several prescribing initiative audits including those aimed at reducing unnecessary anti-microbial prescribing. The practice had achieved 100% of the prescribing incentive scheme targets in the last year.

The practice was involved in quality improvement activity; prescribing of antibiotics of specific conditions was reviewed, including sore throats and otitis media (a group of inflammatory diseases of the middle ear). Both of these audits were repeated and showed improvement. However, there was minimal audit to demonstrate areas where

Are services effective?

(for example, treatment is effective)

improvements may be made and were made in order to drive quality of clinical care. The sore throat audit was completed in 2016 and the only clinical audit shared with us from 2017 was the otitis audit.

The most recent published Quality Outcome Framework (QOF) results were 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 96%. The overall exception reporting rate was 6% compared with the local CCG average of 9% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

We found there was review of daily clinical tasks to prevent backlogs. This included daily checks of prescription requests and pathology result checking.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff told us they were encouraged and given opportunities to develop. For example, a nurse had been able to attend insulin initiation training.

The practice provided staff with

- There was a system to monitor the training uptake of staff and ensuring their skills and knowledge were maintained.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different services and organisations, were involved in assessing, planning and delivering care and treatment.

- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that palliative care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. There were periodic meetings undertaken to review patients receiving palliative care

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- The practice supported national priorities and initiatives to improve the population's health, for example, flu campaigns, healthy eating, stop smoking campaigns and tackling obesity.
- The practice informed us there were 1,125 patients listed as smokers and 448 had been offered advice in recent years.
- Data from Public Health England indicated screening among patients for breast and bowel cancer was lower than national averages. For example, 46% of female patients at the practice (aged between 50-70) had been screened for breast cancer in the last 36 months; this was lower than the CCG average (69%) and the national average (73%).

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

Are services effective?

(for example, treatment is effective)

- Training on the Mental Capacity Act 2005 and Gillick competency (a legal framework for consent in under 16s) were provided to staff.
- There were means of recording consent where necessary.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs and considered these needs in respect of care and treatment planning.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patient feedback suggested practice staff gave patients timely support and information.
- We received 41 patient Care Quality Commission comment cards and 37 were entirely positive with four that contained a mixture of positive and negative comments.

In the July 2017 annual national GP patient survey there were areas the practice was below local and national averages in respect of consultations with GPs and nurses. There had been 342 surveys sent out and 105 were returned. This represented approximately 1.3% of the practice population.

- 80% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average (84%) and the national average (89%).
- 72% of patients who responded said the GP gave them enough time; CCG - 80%; national average - 86%.
- 92% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 92%; national average - 95%.
- 77% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 81%; national average - 86%.
- 80% of patients who responded said the nurse was good at listening to them; (CCG) - 88%; national average - 91%.
- 88% of patients who responded said the nurse gave them enough time; CCG - 91%; national average - 92%.

- 96% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 95%.
- 81% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 89%; national average - 91%.
- 91% of patients who responded said they found the receptionists at the practice helpful; CCG - 85%; national average - 87%.

These scores were assessed by the practice and an improvement plan was implemented immediately after the survey data was published to improve patient perceptions of consultations with nurses and GPs. This included improving information on what expectations patients should have for varying types of appointments. For example, the practice communicated to patients that emergency five minute appointments were for single issues only.

The practice surveyed approximately 150 of its patients to re-gauge the feedback from patients on consultations and compare this to the national survey in November 2017. The questions matched those areas of concern from July 2017. The results showed a significantly more positive outcome. The results were all from patients who attended the practice and so they all had a recent experience of attending the practice compared the national survey where patients are randomly selected and may not have attended the practice for some time. For example, the results showed:

- 93% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average (84%) and the national average (89%) (13% better than the national survey).
- 90% of patients who responded said the GP gave them enough time; CCG - 80%; national average - 86% (18% better than the national survey).
- 99% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 81%; national average - 86% (22% better than the national survey).
- 93% of patients who responded said the nurse was good at listening to them; (CCG) - 88%; national average - 91% (13% better than the national survey).

Are services caring?

- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 89%; national average - 91% (10% better than the national survey).

Involvement in decisions about care and treatment

Staff facilitated patients' involvement in decisions about their care. Leaders were not fully aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given) but there were arrangements to meet the broad range of communication needs within the patient population. For example:

- There was significant ethnic diversity within the patient population, notably patients with an Asian background and Eastern European patients. Translation services were available for patients who did not have English as a first language. There were also multi-lingual staff that might be able to support them, including practice staff speaking South Asian languages.
- Staff communicated with patients in a way that they could understand and information in different languages was available. The practice had successfully endeavoured to increase the number of Asian females to attend the cervical cancer screening programme through various types of communication channels.
- Staff helped patients and their carers find further information and access community and advocacy services. There was a carers' flu clinic organised which the practice had also requested a local carers' support charity to attend in autumn 2017.

The practice identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 35 patients as carers, this equated to approximately 0.5% of the practice list. The low proportion of carers is partially due to a very young patient population.

Staff told us that if families had experienced bereavement, they were contacted with information about support organisations. Results from the national GP patient survey showed patients satisfaction to questions about their involvement in planning and making decisions about their care and treatment was lower when compared to local and national averages:

- 76% of patients who responded said the last GP they saw was good at explaining tests and treatments; CCG - 81%; national average 86%.
- 66% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 76%; national average - 82%.
- 80% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 86%; national average - 90%.
- 76% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 82%; national average - 85%.

The practice's own survey from November 2017 also showed more positive feedback in these areas.

- 94% of patients who responded said the last GP they saw was good at explaining tests and treatments; CCG - 81%; national average 86% (18% better than the national survey).
- 89% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 76%; national average - 82% (23% better than the national survey).
- 92% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 86%; national average - 90%. (12% better than the national survey).
- 88% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 82%; national average - 85%. (12% better than the national survey).

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended opening hours were available, including early morning appointments, evening appointments and weekend appointments.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were provided on the ground floor of the Russell Street and Coley Park surgeries. There were external door bells if patients needed assistance and disabled parking spaces. However, an overall assessment of premises in regards to access for patients with limited mobility or other needs had not been undertaken.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- End of life care was carefully coordinated with the involvement of patients and their families. Religious beliefs were considered in the planning of end of life care and when patients passed away. For example, the practice had set up an ongoing arrangement with the registrar's office for death certificates to be issued at weekends in order for Muslims to have their funerals quickly when this was their belief and preference.

- A hearing loop was available and there are signs advertising the facility.

The practice had a larger print size for their practice leaflet in case this was needed for visually impaired patients.

People with long-term conditions:

- The practice was fully aware of the local challenges with the local health economy, specifically the high prevalence of diabetes. In response, the practice had started a pre-diabetes screening campaign which was audited to identify those patients who would benefit from advice and ongoing diabetes screening.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Practice nurse appointments for these patients were made available following a workforce analysis. Longer appointments were also available.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- The practice held monthly dedicated child immunisation clinics at Russell Street Surgery.
- The practice also ran various weekly clinics to support this group of patient including maternity, contraception and child health surveillance.
- There were same-day emergency morning and evening appointments for children under five.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered Saturday pre-bookable appointments for better access to those who worked full time.

Are services responsive to people's needs?

(for example, to feedback?)

- Online appointment booking was available.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice website was well designed, clear and simple to use featuring regularly updated information. The website also allowed registered patients to book online appointments and request repeat prescriptions.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments and annual health checks for patients with a learning disability.
- The practice was aware of the homelessness issues in the Reading areas and enabled these patients to access services. They also were aware and could refer homeless people to a local church who provided hot meals, clean clothes, bath and shower facilities, use of a telephone and listening time.

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

- The practice was working towards becoming dementia friendly.
- The practice was aware of its higher prevalence of patients with mental health conditions. GPs worked hard to ensure face to face care plans were in place and they had achieved 99% of these.
- To ensure patients with dementia received appropriate care and treatment, the practice had completed additional work in diagnosing dementia.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Home visits were available to patients.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was better when compared to local and national averages. 78% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.

- 82% of patients who responded said they could get through easily to the practice by phone; CCG – 69%; national average – 71%.
- 86% of patients who responded said they were able to get an appointment to see or speak to someone the last time they tried; CCG – 82%; national average – 84%.
- 79% of patients who responded said their last appointment was convenient; CCG – 78%; national average – 81%.
- 76% of patients who responded described their experience of making an appointment as good; CCG – 70%; national average – 73%.
- 75% of patients who responded said they don't normally have to wait too long to be seen; CCG – 53%; national average – 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints with respect.
- The complaint policy and procedures were in line with recognised guidance. We reviewed the practice complaint log and found that they were satisfactorily handled in a timely way.
- The practice had a log of complaints which it used to provide an overall review of complaint type and investigation outcome.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. For example, a complaint regarding phone access led to an investigation of why the phones may not ring if a patient called the practice. This led to a protocol whereby, if the

Are services responsive to people's needs?

(for example, to feedback?)

phones were quiet for 10 minutes or more the router would be reset to ensure that in the unlikely event it had stopped working, the problem would be fixed and enable patients to continue with access to phone lines.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of local and national services. They understood the challenges within the Reading locality and amended services where possible to support the broad section of registered patients.
- Staff told us leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting plans to achieve priorities. For example, there had been improvement in national data submissions regarding long term conditions in recent years.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population and enable collaborative working.

Culture

The practice had a culture of inclusiveness and openness.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.

- The practice focused on the needs of patients. There was a whole team endeavour to improve patient satisfaction.
- Openness, honesty and transparency were demonstrated when responding to safety incidents, complaints and previous Care Quality Commission inspection reports. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. This was reflected in the level of significant event reporting.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals and were supported to meet the requirements of professional revalidation where necessary.
- All staff, including support and reception staff were considered valued members of the practice team. They were given protected time for professional development and yearly evaluation of work and development.
- There was a strong emphasis on the safety and well-being of all staff.

Governance arrangements

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

- The arrangements to monitor care tasks following incoming correspondence posed a risk to patients.
- The monitoring of high risk medicines was not assured at the practice.

All other governance systems ensured:

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

Are services well-led?

Good 

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

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety, other than those identified regarding patient correspondence and high risk medicines.
- Clinical audit had an impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. For example, extensive patient feedback was collected to test improvements to the service.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. This included discussions with the patient participation group (PPG).
- The practice used up to date information technology systems to monitor and improve the quality of care. This had led to improved national data performance in clinical outcomes.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views were encouraged, heard and acted on to shape services and culture.

- The patient participation group was active and involved in discussions and proposals about improving performance of services.
- The practice used the friends and family test to gather patient feedback. Data provided to us by the practice showed 88% patients were extremely likely or likely to recommend the practice from May to August 2017.
- A patient survey undertaken in November 2017 showed very positive results in regards to consultations with clinicians.

Continuous improvement and innovation

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

- Patient feedback in previous years had indicated poor phone access. The practice increased the number of staff answering phones and this had led to a significant increase in positive patient feedback.
- There was a focus on continuous learning and improvement within the practice and local community. For example, the potential for undiagnosed or pre-diabetes within the patient population was high due to the demographic of the population. Therefore a pre-diabetes screening programme had been launched which had identified 55 patients who could be provided with lifestyle guidance and ongoing screening.
- Staff knew about improvement methods and had the skills to use them. The practice had added new health care professionals to the clinical team to cope with an ever changing and ever increasing demand.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice was active and worked collaboratively with the CCG and the local GP Federation. (A Federation is the term given to a group of GP practices coming together in collaboration to share costs and resources or as a vehicle to bid for enhanced services contracts). For example, the practice participated in a scheme to provide Saturday access to patients within the locality and this had increased patient access out of usual working hours.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:</p> <p>Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The registered person did not assess the risks to the health and safety of service users receiving care and treatment; for example:</p> <ul style="list-style-type: none">· There was not a fully functional system to ensure that actions were taken in response to all patient test results or correspondence.· Ongoing monitoring of patients prescribed high risk medicines was not adequate <p>This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>