Peppard Road Surgery

Quality Report

45 Peppard Road
Caversham
Reading
Berkshire
RG4 8NR
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents -

Overall summary

Letter from the Chief Inspector of General Practice

Peppard Road Surgery is located in an urban area of Berkshire. It provides primary medical services to approximately 2200 registered patients.

We carried out an announced, comprehensive inspection on 6 November 2014.

We visited the practice location at 45 Peppard Road, Caversham, Reading, Berkshire,RG4 8NR

Peppard Road Surgery is rated as requires improvement overall.

Our key findings were as follows:

- The practice is rated as requires improvement for safe. We identified areas of concern regarding aspects of staff training, for example, safeguarding children and vulnerable adults and an inadequate recruitment process, including lack of Disclosure and Barring service checks for staff.
- The practice is rated as requires improvement for effective. We identified one area of concern regarding lack appraisals for all staff. The GPs had a thorough understanding of patients' healthcare needs and provided care in line with local and national guidance. However, Quality and Outcomes Framework data showed patient outcomes were variable with the practice performing better in some areas than others.
- The practice is rated as good for caring. Feedback from patients and survey data showed the practice performed above the clinical commissioning group (CCG) and national averages on most aspects of patient satisfaction. We heard many examples of compassionate care from patients.
- The practice is rated as good for responsive. The practice performed significantly better than the CCG average for access to appointments. The practice did not have an accessible complaints policy in place.

Summary of findings

- The practice is rated as requires improvement for well-led. We identified areas of concern regarding the lack of regular performance reviews for staff. The practice did not proactively seek feedback from patients through a patient participation group.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must

- Ensure that criminal records checks through the Disclosure and Barring Service or risk assessments are carried out.
- Ensure staff are supported through appraisals to identify training and development needs
- Ensure staff receive appropriate regular training, for example in basic life support, safeguarding children and vulnerable adults and health and safety

We have issued two compliance actions for the regulations relating to Requirements relating to workers and Supporting workers.

In addition the provider should:

- Ensure that all the recruitment checks are carried out and recorded as part of the staff recruitment process
- Ensure systems are in place for the management of legionella
- Ensure complaints information is accessible to patients
- Ensure feedback is sought from patients, for example, through a patient participation group.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe. We identified a number of areas of concern: there was a lack of safeguarding children training for reception and administration staff and lack of safeguarding vulnerable adult training for all staff. Recruitment checks were not documented in accordance with current regulations including lack of Disclosure and Barring check or risk assessment. There was no system in place for the management of legionella. Cleaning materials were not stored securely. Administration and reception staff had not received training in basic life support. A business continuity plan was in place but had not been fully completed. Staff understood their responsibilities to raise concerns, and report incidents and near misses. Medicines were handled safely and fridge temperatures were checked daily.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective. We identified one area of concern regarding support for staff through lack of training for administration and reception staff and lack of appraisals for all staff. Patients' needs were assessed and care was planned and delivered in line with local and national guidance. This included assessment of capacity and the promotion of good health. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with respect and compassion.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. Patients reported good satisfaction with access to the practice for urgent/ same day appointments and routine appointments. Complaints information was not easily accessible although there was evidence demonstrating that the practice responded quickly to issues when they were raised. There was evidence of shared learning from complaints with staff to improve services.

Summary of findings

Are services well-led?

The practice is rated as requires improvement for well-led. We identified a number of areas of concern: The practice did not proactively seek feedback from patients through a patient participation group (PPG). Staff did not receive regular performance reviews and were not supported to develop in their roles. There were systems in place to monitor and improve quality and identify risk. For example, through fire risk assessment and infection control audit.

Requires improvement 

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

Requires improvement

The practice is rated as requires improvement for care provided to older people. We identified concerns relating to staff recruitment, training and development. The practice had a lower proportion of patients over 55 years compared to the clinical commissioning group (CCG) and national averages. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, allocating older patients early appointments to avoid them travelling home in the dark. The practice was responsive to the needs of older people, including offering home visits and prioritised care for patients with complex needs.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the population group of people with long term conditions. We identified concerns relating to staff recruitment, training and development. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had regular contact with their GP to check their health and medicines needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. We identified concerns relating to staff recruitment, training and development. The practice has a higher proportion of patients up to the age of nine years compared to the local clinical commissioning group (CCG) average. Immunisation rates were in line with all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours. The practice worked in partnership with midwives, health visitors and school nurses to deliver care.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the population group of the working-age people (including those recently retired and students). We identified concerns relating to staff recruitment, training and development. The practice had a higher proportion of patients between 30 to 44 years compared to the clinical commissioning group (CCG) and national averages. The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, for example one late evening surgery was provided each week. The practice performed significantly above average, compared to the local CCG, for patient satisfaction with the access to appointments. The practice was proactive in offering opportunistic health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. We identified concerns relating to staff recruitment, training and development. The practice serves a population which is more affluent than the national average. The practice did not have a register for patients with learning disabilities, although had some younger patients with learning disabilities and met their needs appropriately. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. GPs were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out-of-hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). We identified concerns relating to staff recruitment, training and development. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Six out of nine patients with severe mental health conditions had care plans in place. The GP referred patients to the memory assessment clinic when needed. The practice had a system in place to follow up on patients who had been discharged from hospital to support them in the community.

Summary of findings

What people who use the service say

The 2014 national GP survey results for Peppard Road Surgery based on 103 (39%) responses showed the practice was better in all areas relating to making an appointment compared to the local clinical commissioning group (CCG) average. The practice performed less well on scores of interacting with the nurse during consultations. However, we found the low nurse scores were due to a large proportion of respondents stating the question did not apply to them.

During the inspection on 6 November 2014 we spoke with six patients. All the patients we spoke with were very satisfied with all aspects of the care they received including access to appointments. We received 50 comment cards from patients who had visited the practice over the previous two weeks. All the comment cards expressed gratitude and praise for the care provided by the staff.

Areas for improvement

Action the service MUST take to improve

- Ensure that criminal records checks through the Disclosure and Barring Service or risk assessments are carried out as part of the staff recruitment process.
- Ensure staff are supported through appraisals to identify training and development needs
- Ensure staff receive appropriate regular training, for example in basic life support, safeguarding children and vulnerable adults and health and safety

Action the service SHOULD take to improve

- Ensure that all the recruitment checks are carried out and recorded as part of the staff recruitment process
- Ensure systems are in place for the management of legionella
- Ensure complaints information is accessible to patients
- Ensure feedback is sought from patients, for example, through a patient participation group.

Outstanding practice

The practice provided outstanding access to appointments. The national GP survey indicated 97% of patients described their experience of making an appointment as good compared to the CCG average of 76% and similarly 97% found it easy to get through by phone compared to CCG average of 76%. This was confirmed by the 50 comment cards and patients we spoke with.

Continuity of care was provided by the practice through the availability and longevity of GPs and staff. This enabled the GPs to have acquired extensive knowledge about patients changing health care needs and social circumstances. Feedback from patients indicated this information was used during regular consultations to provide meaningful emotional support and personalised care.

Peppard Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and an Expert by Experience.

Background to Peppard Road Surgery

Peppard Road Surgery is located in a detached house in an urban area. It provides primary medical services to approximately 2200 registered patients. The practice has nine staff, including two GP partners: one male GP and one female GP, one practice nurse, administration and reception staff. The senior partner also manages the practice.

The practice has a higher proportion of patients up to the age of nine years and between 30 to 54 years compared to the local clinical commissioning group (CCG) average and a lower proportion over 55 years. The practice serves a population which is more affluent than the national average.

We visited the practice location at 45 Peppard Road, Caversham, Reading, Berkshire, RG4 8NR

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. The practice holds a General Medical Services contract.

The announced, comprehensive inspection at Peppard Road Surgery took place on 6 November 2014. This was the first inspection since registration. We spoke with six patients and six staff during this inspection.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Prior to the inspection we contacted the North and West Reading Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Peppard Road Surgery. We also spent time reviewing information that we hold about this practice.

The inspection team carried out an announced visit on 6 November 2014. We spoke with six patients and six staff. We also reviewed 50 comment cards from patients who shared their views and experiences.

Detailed findings

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We interviewed a range of practice staff including two GPs, practice nurse, administration and reception staff.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

The practice has a higher proportion of patients up to the age of nine years and between 30 to 54 years compared to the local CCG average and a lower proportion over 55 years. The practice serves a population which is more affluent than the national average.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We reviewed an incident related to incomplete labelling of urine samples. The delays in obtaining results which potentially impacted on patient care and treatment.

We reviewed ten safety records and incident reports and discussed these with the GP. This showed the practice had managed these consistently over time and so could evidence a safe track record over a period of time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was evidence that learning had taken place across GPs and nurses. All staff including receptionists, administrators and nursing staff were aware of the system for raising issues in the practice. We reviewed reports of ten incidents recorded in the previous 18 months. They all showed evidence of analysis, reflection and learning.

National patient safety alerts were received and acted upon by the senior GP. For example, we saw an information notice at the entrance to the practice regarding the outbreak of the viral disease, Ebola, in Africa.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that GPs and nursing staff had received relevant role specific training on safeguarding children. Although, reception and administration staff had not received formal regular training on safeguarding children and vulnerable adults, they had an awareness of potential signs of abuse and said they would refer any concerns to the GP. We noted safeguarding vulnerable adult training for staff was scheduled to take place in the next few months. GPs demonstrated a good understanding of how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out-of-hours. Contact details for the local authority safeguarding team were easily accessible.

One of the GPs was the safeguarding lead for children and vulnerable adults. All staff we spoke with were aware who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and notices available in consulting rooms, although not in the waiting area. Reception and administration staff had been trained as chaperones by the senior GP and were frequently used in that capacity. However, they had not had Disclosure and Barring Service checks performed. Two patients told us they recalled being offered a chaperone prior to an examination.

Patient's individual records were written and managed in a way to help ensure safety. The senior GP preferred handwritten notes. An electronic system (SystmOne) was also used, this collated all communications about the patient including scanned copies of communications from hospitals. The practice had a system for identifying vulnerable patients including children and older patients. Patients on long term medication were regularly reviewed to ensure the appropriateness of continued use.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Fridge temperatures were checked and recorded daily.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance, for example for the administration of flu vaccine.

Prescriptions were stored securely when not in use. The GPs handled all prescriptions personally including requests for repeat medicines. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Requires improvement

Are services safe?

The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

We observed the practice to be clean and tidy. A regular, long standing cleaner carried out cleaning according to the practice's cleaning schedule three times a week. Staff and patients we spoke with told us they had no concerns about the standard of cleanliness or hygiene.

The practice's lead for infection control was the senior partner. An infection control audit had been carried out in the previous month and an action plan in place to make improvements. Staff had not had infection control training.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Regular checks had not been carried out to reduce the risk of infection to staff and patients.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons were available for staff to use.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw a sample of equipment maintenance checks and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Cleaning materials were stored in a cupboard, however it was not secure and located in an area accessible to patients.

Staffing and recruitment

The practice had nine staff, the majority of whom had been in post for many years. We reviewed the record of one member of administration staff who had been recruited in the last two years. We found there was no record of appropriate recruitment checks. For example, proof of identity, references, health check. There was no record of Disclosure and Barring Service (DBS) checks or a DBS risk assessment for administration or reception staff and the senior GP confirmed DBS was not sought for reception or administration staff, although they were expected to act as chaperones when needed.

All staff except for the senior partner worked part-time, most staff worked six to 12 hours per week. Administration and reception staff worked flexibly and covered periods of absence due to sickness or holiday. The practice had not used GP locums for approximately 15 years; the two GPs provided cover for each other. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring safety and responding to risk

The practice was located in small premises and if issues were identified by staff they were immediately raised with the senior GP. For example, security of the practice had recently been improved to safeguard patients and staff.

The practice had a health and safety policy statement, however regular environmental risk assessments were not carried out. Staff had not received training in health and safety.

Systems were in place to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, patients with complex conditions were seen regularly to monitor their condition and review their medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing the GPs and nurses had received training in basic life support and it was scheduled to be updated. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with were aware of the location of this equipment and records we saw confirmed these were checked regularly. Administration and reception staff had not received training in basic life support.

Requires improvement

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A disaster handling and business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, key particulars such as location of the fuse box, water stop valve and contacts of suppliers had not been completed.

Fire equipment was in place; a fire risk assessment had recently been undertaken and the report that included actions required to maintain fire safety was pending. Staff had not received fire training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The evidence we reviewed confirmed the practice aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. The GPs worked very closely and over time had built up extensive knowledge about patients and their family support networks, including social circumstances. This enabled the GPs to tailor treatment to meet patients' healthcare needs. The female GP had an interest in gynaecology, family planning and child health.

All referrals, except for suspected cancers which needed to meet the national two week referral target, were made through Choose and Book. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Referral rates were below the CCG average and were regularly discussed with the CCG by the GPs.

Management, monitoring and improving outcomes for people

The senior partner had overall responsibility for all aspects of patients' care. Designated administration staff had specific responsibilities to ensure records were up to date with, for example child immunisation or whether a patient had attended for cervical smear.

The practice made available one clinical audit which we reviewed. The clinical audit that had been undertaken in the last year. It involved patients treated with vitamin B12 injections and highlighted those who had not attended. A re-audit was planned to review progress.

The practice also used the information they collected for the quality and outcomes framework (QOF- a national voluntary performance measurement tool) and their performance against national screening programmes to monitor outcomes for patients. The practice achievement for the QOF clinical domain was 88%, which was lower than the CCG average. The practice was aware of the areas it had not achieved on, for example it had not referred diabetic patients to a structured education programme, although the majority of other indicators had all been achieved for diabetes. The CQC GP specialist advisor saw a number of examples where the GPs had sought advice from clinical specialists, for example, via the regular virtual diabetic clinics. Another example related to advice from a consultant haematologist. The GPs then applied the learning from this in subsequent cases. For example, to seek genetic advice when there was an unusual blood result.

We saw data from the local clinical commissioning group (CCG) to show the practice participated in the prescribing quality scheme including meeting diabetes targets. The GPs monitored their patients with long term conditions closely through regular appointments rather than issue repeat prescriptions without seeing the patient. The GPs discussed patients to agree strategies to monitor and review those patients' needs. Repeat prescription requests were taken by email and in writing and handled by the GP personally. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area. For example, the practice monitored accident and emergency attendance and was below the CCG average.

Effective staffing

We identified one area of concern regarding the lack of training, for example: fire training, safeguarding, infection control, basic life support, for reception and administration staff. There was also a lack of appraisals and personal development plans for nursing staff, reception and administration staff. Staff were clear of their own responsibilities and duties, however non-urgent tasks were not always covered if a member of staff was absent. For example, summarising new patient registrations.

Both GPs were up to date with their yearly continuing professional development requirements and the senior GP had been revalidated in 2013. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has

Requires improvement

Are services effective?

(for example, treatment is effective)

been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). All aspects of the revalidation had been completed.

The practice nurse kept up to date with the required skills necessary to perform her duties. For example, we saw certificates of attendance at wound management courses, diabetes and health and safety.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service were received electronically and by post. GPs were responsible for reading and actioning any issues arising from communications with other care providers on the day they were received.

The practice held quarterly meetings with the multidisciplinary team including the district nurse, palliative care nurse and occasionally the community matron. These meetings were a forum to discuss the needs of patents with complex needs and vulnerable patients, for example, those with end of life care needs. The practice worked with the community diabetic specialist via virtual clinics. A regular virtual diabetes clinic was held every two to three months with a community diabetic specialist to discuss and advise on the management of particular patients.

The practice worked with the mental health care team to manage patients with severe mental health problems; six out of nine patients with severe mental health conditions had care plans in place.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Referrals were made electronically through Choose and Book.

The practice used paper based records in conjunction with the IT system (SystmOne).The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff were able to coordinate, document and manage patients' care using both systems, although there was some duplication of paper and electronic records.

Consent to care and treatment

We found GPs and nurses were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the GP and nursing staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The GP described a number of patients where their capacity had been determined to uphold their rights. For example, one patient who refused a particular medicine due to the potential side effects. The patient's capacity was assessed and the decision recorded in the patient's notes. Another patient who wished to live at home had been referred to the memory assessment clinic to ensure their best interest was upheld. They were enabled to remain at home with support from social services and the community matron.

All GPs and Nursing staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

Written patient consent was not documented, although the risks of the procedure was explained and documented in the notes, for example, when fitting an intra-uterine contraceptive device.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check. The senior GP told us the practice promoted a holistic approach to care and GPs maximised contact with patients to maintain or improve mental, physical health and wellbeing. For example, opportunistic health checks were carried out for patients over the age of 45 years. The practice had also identified the smoking status of 78.8% of patients over the age of 16. The practice consistently achieved the CCG target of 70% for flu immunisations, one of the GPs visited housebound older patients to administer the flu vaccine.

The practice's performance for cervical smear uptake was in line with the CCG average (81%). The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Requires improvement

Are services effective?

(for example, treatment is effective)

There was wide range of leaflets in the patient waiting room related to health conditions and support groups/ organisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The 2014 national GP survey results for Peppard Road Surgery based on 103 (39%) responses showed the practice was better in all areas relating to making an appointment compared to the local clinical commissioning group (CCG) average. The practice performed less well on scores of interacting with the nurse during consultations. However, the low nurse scores were due to a large proportion of respondents stating the question did not apply to them. In most other areas the practice performed better or close to the CCG average. Ninety four per cent of patients described their overall experience of the practice as good compared with the CCG average of 89%. The number of patients who said they would recommend the practice was lower than the CCG average, however, the number of patients who responded negatively to this question was small.

During the inspection on 6 November 2014 we spoke with six patients. Five out of six patients had partners and children attending the practice and five patients were working age. Two of the patients told us they felt the GP knew their condition very well. For example, if the patient had been seen in hospital a few days after discharge. Four out of six patients noted the attention GPs paid to the pace of information they imparted, particularly when speaking to children and made every effort to involve them in decision making. An example of compassionate care by the practice was in the allocation of earlier appointments for older patients. This was to avoid unaccompanied older patients travelling home in the dark.

All the patients we spoke with were very satisfied with all aspects of the care they received including access to appointments. Everyone was able to obtain urgent and non-urgent appointments when needed. We received 50 comment cards from patients who had visited the practice over the previous two weeks. There was one minor negative comment included on one otherwise positive card; the remainder all described friendly, empathetic care and highlighted the ease of obtaining appointments.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There was one area of the practice where there was a potential breach of confidentiality; patients' names on the appointment diary were visible by patients waiting at the reception desk.

We observed reception staff greeted patients by name and were polite in their interactions. The GP called each patient into the consulting room personally. Waiting times in the practice were short; five minutes or less. This was confirmed by the national GP survey results.

All administration, reception and practice management staff wore identity badges. During the inspection we witnessed a number of caring and discreet interactions between staff and patients to preserve their dignity and privacy. The practice scored above the CCG average for the level of privacy when speaking to receptionists at the practice.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the national patient survey showed the practice was rated above or similar to national average for doctors and nurses involving patients in decisions about their care. For example, the GP specialist advisor saw a record of a patient who had refused a particular course of treatment due to the potential side effects and this had been documented in their notes.

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

Staff told us that translation services were available for patients who needed language support. However, the GPs

Good

Are services caring?

we spoke with did not routinely consider the use of independent translation services when the patient was accompanied by a relative or friend who could act as a translator.

The practice did not maintain a formal register for patients with learning disabilities. However, the GPs and staff knew their younger patients with learning disabilities and reviewed them regularly. The GP specialist advisor saw how patients with learning disabilities and those with mental health conditions were supported to make decisions through the use of care plans which they were involved in agreeing. For example, one vulnerable patient had been referred to hospital for treatment in accordance with their wishes to reduce their stress and anxiety.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received indicated patients were very positive about the emotional support they were offered. Especially, for example, following bereavement.

All the patients we spoke with mentioned how much they valued the emotional support provided by the GPs during consultations and particularly at times of acute illness and bereavement. The GPs encouraged older patients to attend appointments with their younger relatives. This provided opportunities for the GP to involve the family in the care of the older patient and provide information and support.

Carers were identified in the notes and recorded in the patient registration form. Information for carers such as support groups was available in the waiting area.

The practice told us they had a high proportion of working age professionals in stressful occupations. Some of whom had private health insurance. The GP referred patients for anxiety or stress related conditions to private clinics or NHS talking therapies.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice has a higher proportion of patients up to the age of nine years and between 30 to 54 years compared to the local clinical commissioning group (CCG) average and a lower proportion over 55 years. The practice serves a population which is more affluent than the national average.

The practice had two GPs and patients were able to see the male or female GP. Home visits and longer appointments were available for older people, people with long term conditions and those in vulnerable circumstances to meet their needs. The practice had a palliative care register and had regular multidisciplinary meetings to discuss patients and their families' care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. For example, with the out-of-hours service provider.

Tackling inequity and promoting equality

The practice was located on two floors with patient areas on the ground floor. There was ramp access to the entrance for wheel chairs and push chairs. Accessible toilet facilities were available for all patients attending the practice but there was no baby changing facilities. The practice told us they had no patients in wheelchairs, although sometimes patients with mobility scooters did attend. The reception desk was at a height suitable for most patients.

Parking in the area had become difficult due to commuters using the road for all day parking. The practice had recently campaigned with local residents to introduce parking restrictions outside the practice. This was to ensure parking spaces would be available for patients, particularly older patients or those with mobility difficulties. This was due to come into effect shortly.

The GP specialist advisor saw notes to show the GP regularly communicated with some patients who either had a hearing impairment or had difficulty communicating verbally. This enabled patients to have questions answered without time constraints, in between appointments.

Access to the service

Patients were very satisfied with the appointments system urgent and routine appointments. The national GP survey indicated 97% of patients described their experience of making an appointment as good compared to the CCG average of 76% and similarly 97% found it easy to get through by phone compared to CCG average of 76%. This was confirmed by the 50 comment cards and patients we spoke with.

The practice was open 8am to 6.30pm weekdays, except Thursdays. GP appointments were available between 9.15am to 11.15am weekdays and 4.30pm to 6.00pm every week day expect Thursday, when a late evening surgery; 5.30pm to 7pm (and later) was available. Nurse appointments were available on Tuesday mornings only.

Basic information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Online booking and online repeat prescription requests were not available.

Patients told us the registration process was quick and efficient. All new patients were seen by the GP as part of the registration process.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns although, complaints information for patients was not displayed in the waiting area or on the practice website.

Staff said complaints were very rare and if they did receive any complaints they would refer them to the GP. The senior GP handled all complaints. The practice had received four complaints since January 2013, which had all been

Good

Are services responsive to people's needs?

(for example, to feedback?)

resolved. We found the senior GP handled complaints as incidents and these were investigated and analysed for lessons to be shared amongst GPs or other staff to improve practice.

The practice told us feedback was in many forms including letters, cards, NHS email and notes handed in at reception.

The practice leaflet indicated the practice welcomed comments about the practice. None of the patients spoken with had ever needed to make a complaint.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice's statement of purpose included the aim to provide a 'friendly, convenient and efficient service.' They provided continuity of care for their patients through long standing staff and one of the two GPs was always available. The practice did not have a documented business plan in place.

Staff told us the senior GP provided leadership and management of the practice. The senior partner had identified a need to obtain support to reduce their management responsibility, however, this had not yet been implemented.

One of the GPs engaged with the clinical commissioning group by attending the monthly clinical commissioning group meetings.

Governance arrangements

All staff were managed by the senior GP. All staff told us the GPs were very approachable and they were able to raise issues as and when they arose. The practice had nine staff, eight of whom worked part-time, most six to 12 hours per week. Staff were updated, for example, in relation to changes to practice policies and procedures, individually in writing or verbally. Staff meetings were only scheduled if there were sufficient items of importance to convene a meeting for all staff to attend. We reviewed the notes of the last three staff meetings which had taken place between September 2013 and May 2014. There was evidence of discussions regarding practice procedures and development.

The practice used a combination of paper based records and an IT system to manage information. We reviewed a number of policies which had been updated in the previous month and were accessible to staff in hard copy. All staff had signed a confidentiality agreement and we saw records of these. GPs were very diligent in maintaining records and audit trails of all communication and referral letters.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing below the CCG average in some areas. The practice chose to focus its efforts on particular areas of QOF.

The female GP had an interest in gynaecology, family planning and child health and led the practice in these areas.

The practice made available one clinical audit which we reviewed. The clinical audit that had been undertaken in the last year. It involved patients treated with vitamin B12 injections and highlighted those who had not attended. A re-audit was planned to review progress.

Arrangements were in place for identifying, recording and managing risks. The practice was small and issues were identified by staff to the GP as and when they arose. A fire risk assessment had recently taken place and infection control audit which highlighted a number of recommendations. However there was not a comprehensive risk assessment process in place.

Leadership, openness and transparency

The senior GP was responsible for the management of the practice. We spoke with six members of staff and they were all clear about their own roles. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from notes of team meetings which were held infrequently, however we were told this was due to the large number of part-time staff and availability of all staff for team meetings was difficult to manage. Communication was mainly verbal and memorandums to individual staff.

Practice seeks and acts on feedback from its patients, the public and staff

A patient participation group was not in place to gather and facilitate constructive feedback to the practice. The practice welcomed individual patient feedback and information on how to do this was available on the practice leaflet. The practice website contained limited information for patients and some sections stated 'under construction'.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the GPs.

The practice had a whistle blowing policy which was available to all staff in the staff handbook.

Are services well-led?

Requires improvement

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

Management lead through learning and improvement

The senior GP had considered the feedback following his last appraisal and had taken steps to improve management support at the practice in the future.

Reception and administration staff had not received regular training or appraisals to develop them in their roles.

Nursing staff had not received regular appraisals to develop them in their role.

The practice had completed reviews of significant events and other incidents and shared with staff to ensure the practice improved outcomes for patients. For example, we reviewed an incident related to incomplete labelling of urine samples. The GP had raised the issue with the CCG and suggested how the system could be improved.

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 Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered provider did not ensure that the all the information specified in Schedule 3 was available. Regulation 21 (b).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered provider did not have suitable arrangements to ensure persons employed were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users safely. Regulation 23 (1) (a)(b).**