Ashley Centre Surgery

Quality Report

Ashley Centre Surgery
Ashley Square,
Epsom,
Surrey,
KT18 5DD
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Website: www.ashleycentresurgery.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook an announced comprehensive inspection of Ashley Centre Surgery on the 20 November 2014. The practice has an overall rating of good.

Ashley Centre Surgery provides primary medical services to people living in Epsom. The practice is situated in the town centre. At the time of our inspection there were approximately 9,650 patients registered at the practice with a team of four GP partners. Ashley Centre Surgery is a GP training practice and at the time of the inspection was providing training and support for three registrars.

Our key findings were as follows:

- GPs took ownership of all repeat prescriptions requests to ensure patients were receiving correct medicines and had received medicine reviews as necessary.
- Patient feedback about the practice and the care and treatment they received was very positive.
- Infection control audits and cleaning schedules were in place and the practice was seen to be clean and tidy
- An active patient participation group was working in partnership with the practice and there was evidence the practice was listening to its patients.
- The practice had systems to keep patients safe including safeguarding procedures and means of sharing information in relation to patients who were vulnerable.
- There were a range of appointments to suit most patients' needs. However, some patients reported difficulty in calling the practice to book appointments and accessing appointments on the same day with their preferred GP.
- Patients with palliative care needs were supported using the Gold Standards Framework.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice was able to demonstrate that appraisals and personal development plans had taken place for all staff. Staff worked with local multidisciplinary teams to provide patient centred care. Patients had a named GP which allowed for continuity of care and all repeat prescriptions were managed by the patients' GP.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that 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 decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. During the inspection we witnessed caring and compassionate interactions between staff and patients. Patients had access to local groups for additional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access to the practice and continuity of care,

Summary of findings

with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had a system in place for handling complaints and concerns. Information for patients on the complaints procedure was available on the practice website and in the booklet. There was evidence of shared learning from complaints with staff and patients.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions and regular performance reviews. There were both structured and informal meetings that allowed staff to have a say in the running of the practice. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively

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

Good

The practice is rated as good for the care of older patients. Nationally reported data showed that outcomes for patients were positive for conditions commonly found in older patients. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. Clinics included diabetic reviews and blood tests. Blood pressure monitoring was also available. The practice offered personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. When needed longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medicine needs were being met. The GPs followed national guidance for reviewing all aspects of a patient's long term health. Patients with palliative care needs were supported using the Gold Standards Framework. The practice nurses were trained and experienced in providing diabetes and asthma care to ensure patients with these long term conditions were regularly reviewed and supported to manage their conditions. Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young patients. Appointments were available outside of school hours and the premises were suitable for children and babies. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered contraceptive implants and coil fitting. Practice staff had received safeguarding training relevant to their role. Safeguarding policies and procedures were readily available to staff. All staff were aware of child safeguarding and how to respond if they suspected abuse. The practice ensured that children needing emergency appointments would be seen on the day.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). 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, flexible and offered continuity of care. Patients were able to request a GP to telephone them instead of attending the practice. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and 100% of these patients had received an annual health check and agreed an action plan. The practice offered longer appointments for patients with a learning disability where necessary. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. Accessible toilet facilities were available. The practice supported patients who were registered as a carer.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Patients with severe mental health needs had care plans and new cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and local organisations. The practice worked closely with the local mental health team and consultants.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 50 comment cards which contained positive comments about the practice. We also spoke with four patients on the day of the inspection.

We reviewed the results of the national patient survey from 2013 which contained the views of 116 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 93% of patients confirmed the last appointment they had booked was convenient to them. When asked about the overall experience of the surgery 86% said it was good.

The practice provided us with a copy of the practice patient survey results from 2014. Responses were received from 225 patients. The findings indicated that 98% of patients thought the GPs took an interest in the presenting concern and that 97% thought their problem or treatment was explained in full.

We spoke with four patients on the day of the inspection and reviewed 50 comment cards completed by patients in the two weeks before the inspection. Both the patients we spoke with and the comments we reviewed were positive except for one patient and one comment card which gave negative feedback regarding availability of appointments. Comments about the practice included that patients felt listened to, cared for and respected. Comments also included that staff were knowledgeable, professional and friendly. Some of the patients had been registered with the practice for a number of years and told us the practice had supported all of their family members.

Ashley Centre Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP.

Background to Ashley Centre Surgery

Ashley Centre Surgery offers primary medical services to the population of Epsom. There are approximately 9,650 registered patients.

Care and treatment is delivered by four GP partners and three trainee GPs (registrars). There is a mix of male and female GPs. The practice employs a team of three practice nurses and one healthcare assistant. GPs and nurses are supported by the practice manager and a team of reception and administration staff.

The practice runs a number of clinics for its patients which includes travel, child development, immunisations, diabetic and well woman clinics.

Services are provided from:

Ashley Centre
Surgery,
Ashley
Square,
Epsom,
Surrey,
KT18 5DD

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a higher number of patients between 30 and 49 years of age than the national and local CCG average. There are a lower number of patients with long term health conditions. The percentage of registered patients suffering deprivation (affecting both adults and children) was significantly lower than the average for England.

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 was 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.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the Surrey Downs Clinical Commissioning Group (CCG). We carried out an announced visit on 20 November 2014. During our visit we spoke with a range of staff, including GPs, practice nurses, health care assistants (HCAs) and administration staff.

We observed how patients were being cared for and talked with four patients and reviewed policies, procedures and

Detailed findings

operational records such as risk assessments and audits. We reviewed 50 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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.

Good

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, from 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.

We reviewed safety records, incident reports and minutes of meetings from the previous nine months. These showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reported events and issues were recorded onto critical incident reports. We noted that the records were completed in a comprehensive and timely manner. Evidence of action taken as a result was recorded onto the record. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken. For example, a patient had received in error a repeat vaccination. The patient had requested and consented to the vaccination believing they had not received it. We saw recorded there were no health implications and an apology was given to the patient. Learning from the incident indicated the need to always review patient's notes thoroughly.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us that alerts were shared and relevant action taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. There was a dedicated GP lead for safeguarding vulnerable adults and children. All GPs had received level three training in child protection, nursing staff had level two child protection training and reception and administration staff level one. All staff had received safeguarding vulnerable adults training appropriate to their role. We spoke with GPs, nurses, healthcare assistants, reception and administration staff about safeguarding. They could demonstrate they had received the necessary training to enable them to identify concerns. All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern. Contact details for local authority safeguarding teams were easily accessible in the consulting rooms and back offices of the practice.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. The practice manager told us that nursing staff and the healthcare assistant acted as chaperones and had received a criminal records check through the Disclosure and Barring Service (DBS). Two administration staff members we spoke with informed us they had requested to go on chaperone training and were aware of the necessary criminal records checks required. This was confirmed by the practice manager who was in the process of organising the training and the required criminal records checks via the Disclosure and Barring Service. We saw there were posters on display within the waiting room and in each of the GP's consulting rooms which displayed information for patients.

Good

Are services safe?

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

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. There was a clear policy for ensuring that medicines were kept at the required temperatures.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

GPs took ownership of their own patient repeat prescription requests. GPs spoken with told us they used this as an opportunity to review patient medicines. Where changes were identified the GP liaised with the patient to describe why the change was necessary and any impact this may have. They told us it also ensured that all necessary clinical alerts were dealt with quickly and made it easier to check unnecessary medicine requests. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Vaccines were administered by nurses using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives and evidence that nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We reviewed records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the practice had carried out infection control audits and no areas of concern had been highlighted. We observed that the practice was clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow, for example, hand hygiene, a spillage protocol, management of sharps injuries and clinical and hazardous waste management.

Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. Hand washing guidance was available above hand washing sinks and there were wall mounted soap dispensers and hand towels at every sink throughout the practice.

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 equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment. For example, weighing scales.

Staffing and recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff. There was also a system for members of staff, including GPs, nursing and administrative staff to cover annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

The practice had not employed any new staff for six years, therefore files we reviewed were not governed by our regulation at the time of recruitment. We spoke with the practice manager regarding the current recruitment process. They were able to explain to us the information required to ensure that new staff members were suitable and of good character before being employed. This included receiving a CV which contained a full employment history with no gaps in employment, photographic proof of identify, references from relevant past employers, qualifications, registration with the appropriate

Good

Are services safe?

professional body and a criminal records checks via the Disclosure and Barring Service. We reviewed the practice recruitment policy which also referred to the Health and Social Care Act 2008 regulations.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered double appointments when necessary.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency medicines and equipment were available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All staff asked knew the location of this equipment and records confirmed these were checked regularly. All the medicines we checked were in date and fit for use.

A disaster continuity business plan had been developed to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral into secondary care, for example patients with suspected cancers were referred and seen within two weeks.

A review of case notes for patients showed that all were on appropriate treatment and had regular reviews. The practice used computerised tools to identify patient groups who were on registers. For example, carers, patients with learning disabilities or patients with long term conditions. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

GPs checked all patient repeat prescriptions requests. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management.

We spoke with a partner GP who told us that audits played an important role within the practice. GPs and nurses we spoke with told us that audits were used to improve patient care. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of GPs and nurses. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. The practice completed audits linked to updated guidance, medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. Individual GPs and GP registrars completed their own audits which were discussed at partner meetings. We were told that around 30 audits were completed each year. We saw a sample of these audits, which included a review of patients receiving a specific medicine for peripheral vascular disease after an update from the National Institute for Health and Care Excellence (NICE). We saw that two reviews had taken place six months apart, to record and monitor changes in the practice's prescribing.

Other examples of clinical audit included coils and implants, diabetes, analysis of our casualty attendance, a prescribed blood thinning product and a specific medicine for **osteoporosis.**

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 93% of patients with rheumatoid arthritis had a face-to-face annual review in the last 12 months. We also noted that QOF data showed that 95% of patients experiencing poor mental health had a comprehensive care plan. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice provided specific appointments for patients to help them manage and improve their health and wellbeing. These appointments were relevant to the different population groups, patient needs or specific for the types of illnesses to either help patients manage long term conditions or improve their quality of life. For example, cervical smear tests, diabetes and asthma clinics.

We saw evidence that the GPs reviewed relevant medicines alerts when prescribing medicines. After receiving an alert, the GPs reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, safeguarding children and vulnerable adults. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, asthma, diabetes and travel health.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs, a cancer diagnosis or children on the at risk register. These meetings were attended by district nurses, social workers, local hospice staff and palliative care nurses. Staff felt this system worked well.

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. Electronic systems were used to make referrals. This system enabled patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

The practice had systems available to provide staff with the information they needed. An electronic patient record was created within EMIS Web and was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The policy also gave guidance about withdrawal of consent by a patient. A form was available to record consent where appropriate. Gillick competencies were also referred to in the policy. Gillick competencies relate to whether or not a child under the age of 16 has sufficient understanding and intelligence to enable them to understand fully what is proposed, then they will be competent to give consent for themselves**.** The GPs we spoke with told us they always sought consent from

Good

Are services effective?

(for example, treatment is effective)

patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs of using their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriate timed intervals.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. We reviewed our data and noted that 93% of children aged below 24 months had received their mumps, measles and rubella vaccination. The practice's performance for cervical smear uptake was 82%, which was comparable with other practices in the local clinical commissioning group (CCG) area but above the national average

Data showed us that the practice had identified the smoking status of 85% of patients over the age of 16 which was comparable with other practices in the CCG area but above the national average. The practice had offered support and treatment to 74% of those patients to help them give up smoking.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced two websites for patients looking for further information about medical conditions. The practice booklet included a list of useful telephone numbers. This included social services and support groups for patient reference.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 50 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were efficient, helpful and considerate. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 86% of patients rated their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 88% of practice respondents saying the GP was good at listening to them and 87% saying the GP gave them enough time.

We also reviewed a practice patient survey from 2014 of which the practice received 225 replies. Results showed that 97% of patients would describe the service as being good or very good. When asked the question if they felt the GP took an interest in what the patient was presenting to them 98% said they agreed or strongly agreed.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The practice had two reception areas and waiting rooms. One on the ground floor and another on the first floor. On the ground floor the reception area was situated away from the waiting room which allowed for a greater privacy for patients. On the first floor the reception area was situated in the waiting room. Staff were able to give us practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view, asking patients if they wished to discuss private matters away from the reception desk and confirming dates of birth rather than patients names when taking phone calls. The GP national survey showed that 79% of patients were satisfied with 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 generally rated the practice well in these areas. For example, data from the national patient survey showed 80% of patients said the GP involved them in care decisions and 78% felt the GP was good at explaining treatment and results. We also reviewed the practice survey from 2014 and when patients were asked if they felt content knowing that they had an input in the kind of treatment they would be receiving 92% of patients agreed or strongly agreed.

Patients we spoke with on the day of our inspection told us that 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

We viewed the records of patients with long term conditions which contained care plans which were well recorded and evidenced patient involvement. GPs we spoke with told us of the various ways they supported patients to understand conditions and treatments. This included using diagrams or printing information that patients could read at home.

Staff told us that translation services were available for patients who did not have English as a first language as well as signing for patients who were hearing impaired.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations. The practice computer system alerted

Good

Are services caring?

GPs if a patient was also a carer. We saw written information available for carers to ensure they understood the various avenues of support available to them. The practice had a register of patients who were carers.

One patient we spoke with told us they felt the doctors and nurses were particularly good at treating their children with care and involving them in discussions. Patients told us via the CQC comment cards that they had been supported by the practice during difficult periods in their lives. 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.

Staff told us that if families had suffered bereavement, their GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 patient 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.

There had been very little turnover of staff during the last three years. GPs had their own patient lists and repeat prescriptions were completed by the patient's own GP which enabled good continuity of care. Longer appointments were available for patients who needed them and those with long term conditions. GPs completed telephone consultations each day and home visits could be requested when necessary.

GPs supported patients living in two homes for people with learning difficulties and mental health problems. GPs knew the patients and their carers well and proactively supported them in attending health checks. GPs also supported students at a local boarding school.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). For example, the patient survey had highlighted that a percentage of patients would like to have practice information sent to them via text or a newsletter. The practice was collecting mobile phone numbers from patients who wished to use this type of communication and a few patient comments we received told us they appreciated text reminders of appointments and felt this service was working well. We also saw clearly on display in the waiting room areas the practices newsletter.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff told us that those patients with no fixed abode could register and be treated at the practice. The number of patients with a first language other than English was low. Staff knew how to access language translation services if these were required.

Staff we spoke with told us they felt the building was no longer able to accommodate the needs of their growing patient list. The practice manager and a partner GP explained that suitable premises had been located but had been placed on hold due to circumstances beyond their control. Some patients who had left comments on our CQC comment cards also echoed the need for better premises.

There was limited access to the practice for patients with disabilities or mobility problems. Patients who used wheelchairs or had restricted mobility were able to gain access via a rear entrance with ramp. However, staff informed us this could sometimes be blocked by delivery lorries to the neighbouring shops. Patients used a telecom and buzzer to ask staff to open the door. We noted that none of the doors had an automatic opening mechanism. There were two toilets for patients on the ground floor. The female toilets were also used as a toilet for disabled patients and had nappy changing facilities for patients with babies. Appointments were given to those patients with restricted mobility in ground floor clinical rooms and their GP swapped rooms in order accommodate these patients and to ensure continuity of care.

Access to the service

The reception staff were available from 8am to 6.30pm on weekdays to enable patients to book appointments. The GP surgery times were different and the practice leaflet gave comprehensive details of times when GPs ran their surgeries. We noted there was an early morning surgery from 8am each day and on a Wednesday another surgery was open at 7.30am. The practice had one late evening surgery which ran until 8pm. These surgeries were run specifically to help the commuter population. Appointments could also be booked with the nurses and healthcare assistant. Nurses also ran specific times for different clinics. For example, well woman clinics were run by the practice nurses each Monday between 12pm and 2.15pm and Wednesday from 10.30am until 11.30am.

There were arrangements in place for patients who needed urgent medical assistance when the practice was closed. There was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the Out of Hours service was provided to patients on the website, practice leaflet and appointment information advertised in the practice.

Information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent and routine appointments, telephone consultations and home visits and how to book appointments through the website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. Patients spoken with and comments left on CQC comment cards confirmed that patients were mainly happy with the appointment system. Most reported that they had been able to get an appointment on the same day if they were prepared to see any doctor available. Some patients told us there could be a delay in seeing the GP of their choice but were able to get emergency appointments for that same day.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

Information was available to help patients understand the complaints system. The practice website and practice leaflet had details explaining the process and we noted there was a complaints poster in the waiting areas. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice would acknowledge the complaint within three working days and start an investigation and a written explanation given with ten working days. Complainants would be invited into the practice to discuss issues with either the practice manager or a GP. Patients were provided with information about how to take their complaint further if they were not satisfied with the outcome of the practice investigation. The practice discussed any complaints with relevant staff and action points were recorded.

We looked at the complaints log for those received in the last twelve months and found these were all discussed, reviewed, learning points noted and shared at meetings. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice vision was to deliver high quality care and promote good outcomes for patients. Staff knew and understood the vision and knew what their responsibilities were in relation to these. Staff spoke positively about the practice and thought that there was good team work. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. Many of the staff had worked at the practice for a number of years and all the staff we spoke with were positive about the open culture.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice and printed out in the staff room. This included fire safety, whistleblowing, complaints, equality and diversity, chaperoning and safeguarding policies for both vulnerable adults and children. We reviewed a selection of policies and procedures and these had been reviewed annually and were up to date.

The practice held regular clinical meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. We saw that QOF data, clinical audits and significant events was regularly discussed at these meetings. Meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team.

GPs led on specific areas, for example there were lead roles for safeguarding, diabetes and minor surgery. We spoke with 12 staff members and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw audits for coil insertions, diabetes, wound care and patients who were taking high levels of repeat medicines.

Leadership, openness and transparency

We saw from minutes that partner meetings were held weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues. Administration and reception staff we spoke with told us that their meetings were not held regularly but that communication was very good within the practice. They told us that they had opportunities to discuss any concerns or give suggestions with the practice manager or the partner GPs and they were always made aware of any new developments or changes within the practice. Staff told us that social events had been arranged in the past. These events were used to for senior staff members to thank staff for their work and provided an opportunity for reflection.

There were policies and procedures in place to support staff in their roles. These included infection control and whistleblowing. Staff were aware of the whistle blowing policy and gave us examples of where they had reported concerns to the partner GPs. They told us they knew it was their responsibility to report anything of concern and knew the GP partners would take their concerns seriously and support them.

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

The practice had gathered feedback from patients through patient surveys, a suggestion box and compliments and complaints received. We looked at the results of the annual practice patient survey from 2014, where 225 responses were received. The results of the survey were advertised on the practice website. The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups; including older patients and different ethnicities. The PPG had carried out surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. We contacted two members of the PPG. We were told that the last survey indicated patients were unhappy with the phone line when calling to make an appointment. Patients indicated that as the phone continued with a ringing tone they were unaware

Are services well-led?

Good

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

that they were in a queuing system and felt their calls were not being answered. The practice had taken on board this feedback and was in the process of changing to an automated phone system which made the patient aware of how many callers were in front of them.

The practice had gathered feedback from staff through staff discussion, meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Two members of staff told us that they had asked for specific training around chaperoning and this was in the process of being arranged. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan and identified any training. Staff told us that the practice was very supportive of training and that they sometimes had guest speakers.

The practice was a GP training practice and at the time of the inspection had three registrars GPs at the practice. One of the GP partners supervised the doctors at all times. Occasionally, the practice also taught medical students.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.