Ashlea Medical Practice - Linden House

Quality Report

Linden House,
30 Upper Fairfield Road,
Leatherhead
Surrey,
KT22 7HH
Tel: 01372 375666
Website: www.ashlea.nhs.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?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ashlea Medical Centre – Linden House on 13 November 2015. Overall the practice is rated as good.

The provider has two practice locations. Linden House situated in Leatherhead and Gilbert House situated in Ashtead. We inspected both practices separately. This report relates to Linden House. Gilbert House was inspected on 5 November 2014 the details of which can be read in a separate report.

Linden House provides primary medical services to people living in Leatherhead. The practice is situated in a residential area.

At the time of our inspection there were approximately 9,300 patients registered at the service with a team of five GP partners who held managerial and financial responsibility and two salaried GPs. Linden House is a GP training practice and at the time of the inspection was providing training and support for two registrars.

The inspection team spoke with staff and patients and reviewed policies and procedures implemented throughout the practice. The practice was responsive to the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice. The practice was committed to providing high quality patient care and provided good support and training to staff to facilitate this. The practice is required to record significant events onto an annual summary and we saw this was not routinely being completed. GP's told us all significant events and lessons learnt were discussed during daily meetings, however, these meetings were not recorded. We noted that some care plans were hand written and not being recorded on to patient's electronic records. This did not allow for other clinicians to see actions agreed with the patient for their ongoing care.

Our key findings included:-

- Patients told us they felt they were treated with respect and dignity

Summary of findings

- Staff were mindful of patient privacy and confidentiality was maintained.
- Patients told us there was a wide range of appointments, including urgent appointments available the same day.
- Infection control audits and cleaning schedules were in place and the practice was seen to be clean and tidy
- An active patient participation group working in partnership with the practice

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Record all significant events and ensure that regular review meetings are held and documented to demonstrate that the practice had learnt from these and that findings are shared with relevant staff.

In addition the provider should:

- Record minutes from reception staff meetings
- Ensure all staff are offering the chaperoning services to all patients
- Ensure all staff complete safeguarding for Vulnerable Adults training
- Record all care plans onto patient electronic records in a way that allows for sharing of information

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 safety.

The practice is required to record significant events onto an annual summary and we saw this was not routinely being completed. We saw two significant events that had been recorded onto the annual summary were actioned to reduce the risk of recurrence. However, GPs we spoke with were able to give us other examples of significant events that had not been recorded. GPs told us these were discussed at their daily meetings however, these meetings were not recorded and there was no evidence that discussions had taken place or if events were used by staff for continuous learning.

Patient's individual electronic records were written and managed in a way to help ensure safety. However, we noted that some care plans were hand written and not being recorded on to patient's electronic records. This did not allow for other clinicians to see actions agreed with the patient for their ongoing care.

The practice had safeguarding policies and procedures in place to protect children and vulnerable adults. Two safeguarding leads had been appointed who had undertaken appropriate safeguarding training. Staff told us they would raise any concerns they had with the GP if they suspected abuse. 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. Recruitment was carried out effectively to ensure that staff were suitable, and had the skills, knowledge and qualifications necessary to carry out their role safely. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data we reviewed showed us the practice had achieved 99% of the clinical targets contained in the national quality and outcome framework standards (QOF). Staff referred to guidance from the National Institute of Clinical Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. GPs and nurses understood their role in assess patients' mental capacity to understand care and treatment and to promote good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify appraisals and

Summary of findings

the personal development plans for staff. Staff worked with multidisciplinary teams to provide patient centred care. For example, health visitors and palliative care teams. A range of health promotion material and services were available to patients. The practice offered a range of health clinics to meet the needs of patients who used the practice. These included diabetes clinics, baby clinics and asthma clinics.

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. We spoke with five patients, who were very positive about all aspects of the care they received. This was supported by the ten comment cards we received. 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. 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, 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 booklet. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing services which were well led. There was clear leadership and team working to the benefit of patients. The practice was developing strategic plans for the future. The practice had a number of policies and procedures to govern activity The practice had a patient participation group (PPG). There were audits and risk management tools to ensure patient, staff and visitor safety. 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 people. Patients over 65 years made up 32% of the practice's population group which was above the national average. The practice provided services for patients in nursing homes. 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, blood tests and blood pressure monitoring was available. Multidisciplinary meetings took place monthly to discuss at risk patients and those needing palliative care. There was good communication between the practice and other services including the community matron, social services and support organisations for carers. Community matrons are highly experienced senior nurses who work closely with patients in the community to provide, plan and organise their care. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older people.

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 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. GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.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 practice was 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. We were provided with good examples of joint working with midwives and health visitors. Practice staff had received safeguarding training relevant to their role. Safeguarding policies and procedures were

Summary of findings

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. The practice had links with counselling services for 15 to 25 years olds.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). Patients could book appointments either by telephoning, in person or on line via the practice's website. This ensured patients were able to book appointments with the practice at times and in ways that were convenient to them. The practice had several late evening and early morning appointments to accommodate those patients that worked. Patients reported that access was mainly good. 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 which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice supported patients with a learning disability registered with the practice and supported patients who lived at a learning disabilities care home. The practice carried out annual health checks for patients with a learning disability and 98% of these patients had received a health check. The practice could offer longer appointments for patients with a learning disability. Patients not registered at the practice could access services and translation services were available for patients who did not use English as a first language. The practice had good access for those with limited mobility or who used wheelchairs. Accessible toilet facilities were available. The practice supported patients who registered as a carer. The practice had good links with the local night shelter and supported transient patients to access care. The practice was aware and advertised other services that could provide support for this population group.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including patients with dementia). The practice offered a range of services to patients experiencing mental health problems and 90% of patients experiencing poor mental health had received an annual physical health check.

Summary of findings

Patients could be referred to in–house counselling services if appropriate. The practice had a lead GP for mental health. The practice was aware that data showed they were below average for diagnosing dementia. The practice was investigating this further. A range of leaflets detailing support groups for people with poor mental health were available in the practice.

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 ten comment cards which contained positive comments about the practice. We also spoke with five patients on the day of the inspection.

All the patients we spoke with were positive about the service they received. They told us they were treated with respect and staff were helpful. However, they told us that although they could get appointments of their choice it may not be with their named GP. This was echoed in a few of the comment cards we reviewed. Patients also commented that it could be difficult to contact the practice in the morning by telephone for appointments.

Comments received through the comments cards were positive about the service patients received. Most told us that appointments were readily available. Comments about the practice included that patients felt listened to, respected and treated with dignity. Comments also included that staff were understanding, professional, polite and helpful.

We viewed the results for the patient survey completed in 2013 by the national patient survey. The survey had received responses from 116 patients. The findings indicated that 86% of patients described their overall experience of the practice as good. The findings also indicated that 83% of patients would recommend the practice to someone new in the area.

Areas for improvement

Action the service MUST take to improve

- Record all significant events and ensure that regular review meetings are held and documented to demonstrate that the practice had learnt from these and that findings are shared with relevant staff.

Action the service SHOULD take to improve

- Record minutes from reception staff meetings
- Ensure all staff are offering the chaperoning services to all patients
- Ensure all staff complete safeguarding for Vulnerable Adults
- Record all care plans onto patient electronic records in a way that allows for sharing of information

Ashlea Medical Practice - Linden House

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 Ashlea Medical Practice - Linden House

The provider has two practice locations. Linden House situated in Leatherhead and Gilbert House situated in Ashtead. We inspected both practices separately. Gilbert House was inspected on 5 November 2014, the details of which can be read in a separate report. GPs, administration staff and receptionists were assigned to their own practices. However, nurses could work across both practices. The practice manager and the assistant practice /human resources manager worked across both practices. All staff were able to offer support to the other practice when needed. For example, in the event of staff sickness. Both practices shared policies and procedures and completed clinical audits jointly.

We visited the practice location at Linden House, 30 Upper Fairfield Road, Leatherhead, Surrey, KT22 7HH. Linden House is located in a residential area of Leatherhead and provides a range of primary medical services to approximately 9,300 patients.

Linden House has five partner GPs and two salaried GPs. There are four female GPs and three male. The practice is open 8am until 6.30pm. Appointments are available from 8am. The practice runs one early morning and three late night sessions. Appointments may be booked up to a month in advance and every day there are several appointments made available for each doctor. Patients who called for an urgent appointment were seen on the day.

Linden House also employs five practice nurses and a healthcare assistant. GPs and nurses were supported by a practice manager and assistant practice/human resources manager as well as a team of 24 administration staff including receptionists.

The practice runs a number of clinics for its patients which includes child development, immunisations, diabetes, ophthalmology and well woman clinics. (Ophthalmology is the branch of medicine that deals with the anatomy, physiology and diseases of the eye).

The practice had opted out of providing out of hours services to their own patients. There were arrangements in place for patients to access emergency care from an Out of Hours provider.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. 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.

Detailed findings

How we carried out this inspection

Prior to the inspection we contacted the local clinical commissioning group, NHS England area team and local Health watch to seek their feedback about the service provided by Ashlea Medical Practice – Linden House. We also spent time reviewing information that we hold about this practice. 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.

The inspection team carried out an announced visit on 13 November 2014. We spoke with five patients and 12 members of staff. This included the practice manager, four GPs, two practice nurses and a healthcare assistant and four reception staff. We also reviewed ten comment cards from patients and spoke with two members of the patient participation group.

As part of the inspection we looked at the management of records, policies and procedures, and we observed how staff cared for patients and talked with them.

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)

The practice had a slightly higher than average percentage of registered patients who were aged 30-49 years of age than the average for England. The percentage of registered patients aged over 65 years was slightly higher than the average for England. The percentage of registered patients suffering deprivation (affecting both adults and children) was significantly lower than the average for England.

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 to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice had a system in place to circulate alerts from national bodies such as the Medicines and Healthcare Products Regulatory Agency (MHRA). Information relating to withdrawal or a dose change for specific medicines was passed to the GPs to be actioned. We were told by the GPs we spoke with that patients affected were contacted and the necessary changes made in consultation. There was a system in place where all GPs needed to sign to indicate they had completed any action required from alerts received.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice is required to record significant events onto an annual summary and we saw this was not routinely being completed. The practice had recorded two significant events which had taken place over the last 12 months. However, after talking with the GPs it was recognised that significant events were taking place but were not being recorded in the annual summary. GPs we spoke with told us of other significant events which had been discussed at the GP's daily meetings and used in their revalidation. GPs we spoke with told us discussions ensured that appropriate learning took place. However, the daily meetings were not recorded so we were unable to see evidence that findings were communicated to all relevant staff to allow for appropriate learning.

We reviewed a significant event recorded which had resulted in the update of the practice's alarm system to request help from other staff. We saw this was checked on a more frequent basis. Nurses and administration staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

National patient safety alerts were disseminated by e-mail to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the daily meetings to ensure staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding children. Staff knew how to recognise the signs of abuse in vulnerable adults and children. They were also aware of their responsibilities and knew where to find contact information for relevant agencies. The practice manager was aware that safeguarding adults training had not taken place and told us this had been arranged for December 2014. Staff we spoke with confirmed they were aware of training planned.

The practice had dedicated GP leads for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

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 only nursing staff acted as chaperones. We saw there were posters on display within the waiting room and surgeries which displayed information for patients. One member of staff we spoke with told us they did not always offer a chaperone to their patients in the case of an intimate examination. We discussed this with a partner GP and the practice manager who told us they would arrange further training to ensure all staff were aware of the reason behind offering a chaperone.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called EMIS which collated all communications about the patient including scanned copies of communications from hospitals. However, staff told us that some care plans were not routinely recorded in

to patient electronic notes and instead they had been hand written. There was a concern that actions agreed by the patient may be missed by other nurses or GPs by not being recorded onto the case notes.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

Medicines management

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

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. Staff ensured that medicines stored within refrigerators were kept at the required temperatures, and could describe the action to take in the event of a potential failure. 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.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions 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. We viewed the legionella assessment carried out by an external company which contained an action plan. We saw evidence the practice manager was in the process of arranging for these actions to be completed.

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.

The practice had a lead for infection control. We saw evidence the practice had carried out infection control audits which included an infection control inspection checklist. The check list ensured that different areas of infection control were reviewed. We saw actions plans had been created for any concerns raised.

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. Staff told us they had supplies of gloves and other personal protective equipment.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained. For example, records to demonstrate that medicine refrigerators were routinely checked. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The practice manager showed us a record of a maintenance schedule of testing. We saw evidence of calibration of relevant equipment, for example weighing scales.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting members of staff.

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. The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and could be available for annual

Requires improvement

Are services safe?

leave and sickness absence cover. Staff told us there were 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. Staff told us that if required cover could be requested from the providers other site. This included GP cover if necessary.

Monitoring safety and responding to risk

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

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. The practice's significant event summary notes showed that staff had discussed a medical emergency concerning a patient and that the practice had implemented the learning from this.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable disaster recovery and business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

There were environmental risk assessments for the building. For example, fire assessments and electrical equipment checks had been completed. All staff we spoke with were aware of their responsibilities in the event of a fire. We also saw evidence of the last infection control audit which had been completed in February 2014.

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 of patients with suspected cancers being seen within two weeks. Patients had their needs assessed and care planned in accordance with best practice.

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.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. 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.

The GPs told us clinical audits were often linked to 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. For example, we reviewed a clinical audit reviewing patients who were on a combination of two specific medicines where research indicated there were no clinical benefits. Following the audit, the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

Other examples of clinical audit included a review of referrals of patients to the ophthalmologist, stroke prevention and auditing of patients on a specific medicine having a thyroid function test in a required time frame.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 94% of patients with diabetes had an annual review. This practice was not an outlier for any QOF (or other national) clinical targets.

Effective staffing

The practice staff team included GPs, nurses, managerial and administrative staff. We were told by staff that they had completed training in basic life support, hand washing, confidentiality and safeguarding children. We saw records that confirmed this to be the case. We saw that GPs and nurses had also completed specialist clinical training appropriate to their role, for example in diabetes, asthma, family planning and updates in childhood immunisations.

We were told by staff that they received annual appraisals and informal supervision. All the staff we spoke with felt they received the on-going support, training and development they required to enable them to perform their roles effectively. We saw records that confirmed annual appraisals were undertaken for all staff. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council). 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. We received positive feedback from the trainees we spoke with.

Good

Are services effective?

(for example, treatment is effective)

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 or management of diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. The practice held multidisciplinary team meetings every month to discuss patients with complex needs, for example those requiring end of life care. These meetings were attended by community nurses and palliative care nurses.

The practice 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. Staff were aware of their responsibilities in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. There was a system for GPs to review results for absent colleagues.

The practice worked closely with the ophthalmologist who attended the practice fortnightly. The practice also had counselling services on site that patients could be referred to. Staff told us there were strong links with voluntary sector groups who could provide emotional and practical support to patients, including the older population.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record, EMIS was used by all staff to coordinate, document and manage patient 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.

All staff told us that the practice had daily GP meetings which they could attend if they wished. The GPs held discussions which related to patients, referrals, medicine alerts and any relevant information. We were told that daily meetings were not recorded. We saw that the monthly management meetings were formally recorded.

Consent to care and treatment

GPs we spoke with had an understanding of the Mental Capacity Act 2005 (MCA). They knew when it may be required to assess someone's capacity to make a decision and how a decision can be made in a patient's best interests. The practice MCA policy contained detailed information on how to assess the capacity of a patient and GPs used a mental capacity assessment checklist.

GPs and nurses described the process for gaining consent from patients who were under 16 years of age and could demonstrated a clear understanding of the Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

We saw the practice had a consent policy and forms for patients to consent to specific procedures in the practice. For example, patients signed a consent form to allow medical students to be present during their consultations with GPs or nurses.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

There was information on various health conditions and self-care available in the reception area of the practice. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care.

The practice had systems to identify patients who required additional support and were pro-active in offering additional help. For example, vaccination clinics were promoted and held at the practice, including flu vaccination for older patients. QOF data showed that 92% of female patients had received a cervical cancer screening test and that 94% of patients with diabetes had received an annual health review. QOF data we reviewed also showed that vaccine rates for children were at 97%.

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 ten completed cards and all were positive about the service experienced. Patients said they felt the practice offered a caring service and that staff were efficient, helpful and considerate. They said staff treated them with dignity and respect. We also spoke with five 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.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We noted that the reception area and waiting room did not allow for privacy when patients booked in. 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.

We reviewed the most recent data available for the practice on patient satisfaction from the national patient survey. Patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with GPs and nurses with 90% of practice respondents saying the GP was good at listening to them and 86% saying the GP gave them enough time.

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 78% of practice respondents said the GP involved them in care decisions and 82% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area.

Patients we spoke to 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 patient records with long term conditions which contained care plans which were well recorded and provided evidence of 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.

We spoke with staff regarding vulnerable patients accessing the practice. Staff informed us that patients, who may have potential difficulties accessing the practice for various reasons, were centrally recorded so that arrangements could be made when appointments were booked. For example, patients might be offered the first appointment of the morning surgery or ensure a wheelchair was available.

Patient/carer support to cope emotionally with care and treatment

Notices and leaflets in the patient waiting room, and practice website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Information for carers was available at the reception desk to ensure they understood the various avenues of support available to them.

Staff we spoke with told us that the practice was pro-active at offering support to it patients. For example, the practice had close connections with a local organisation that offered support to older members of the community in relation to practical support and companionship. The

Good

Are services caring?

patient participation group informed us that they held open meetings to the public four times a year. Talks on health related topics given by either a specialist in the subject or a doctor from the practice were held at these meetings. Recent talks had included carers groups in the community and the manager of the centre for elderly day care. They had described the activities on offer, the support for carers and specialised help for people with Alzheimer's.

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.

There had been very little turnover of staff during the last three years which enabled good continuity of care. Longer appointments were available for patients who needed them and those with long term conditions.

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, in the eighteen months since the PPG has been established four patient surveys had been completed. This had included surveying patients with a diagnosis of rheumatoid arthritis. Patients answered questions on their experience of care, care coordination and their overall satisfaction. Results were discussed with the practice and actions were agreed, which included raising awareness for reception staff, ensuring annual reviews were completed and that patients were under a named consultant in the local rheumatology department.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, staff told us that patients who were of no fixed abode could be registered as a temporary resident and there were strong links with the local shelter in Leatherhead to support this patient group.

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.

The premises and services were able to meet the needs of patients with disabilities. The practice was situated on over two floors. Patients were seen on the ground floor and staff offices, meeting room and kitchen facilities were found on the first floor. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Toilet facilities were available for all patients and included baby changing facilities. The toilet for disabled patients contained grab rails for those with limited mobility and an emergency pull cord.

Access to the service

Appointments were available from 8am until 6.30pm on weekdays. Patients could call to make appointments from 8am and there were Online facilities for patients to book appointment at times convenient to them. The practice had extended access and opened early one morning and had three late evenings a week. Appointments could be booked on the day or up to one month in advance. Urgent appointments were available throughout the day.

Information was available to patients about appointments on the practice website. This included how to arrange home visits, how to book appointments through the website and the number to call outside of practice hours. Patients were also given information through a practice leaflet.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Patients were advised to call the Out of Hours service.

Patients spoken with and comments left on CQC comment cards confirmed that patients were mainly happy with the appointment system. Several comments were in relation to the delay in calls being answered first thing in the morning. However, most reported that they had been seen 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 if it was urgent they were always able to get an appointment for that same day. One patient we spoke with told us they had been able to book two appointments one after the other, in order for their children to be seen together and was at a time that suited them.

Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints system. The practice website had details

Good

Are services responsive to people's needs?

(for example, to feedback?)

explaining the process and we noted there was a complaints procedure leaflet available for patients. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice would acknowledge the complaint within two working days and start an investigation. Complainants would be kept informed of any updates and where possible would be invited into the practice to discuss their complaint further. 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 at the GP's daily and weekly meetings and with relevant staff and action points were recorded.

We reviewed three complaints which had been received in the last 10 months. We saw that an investigation had been completed. Learning had been discussed with staff and recorded to ensure lessons could be learnt and new processes adopted where necessary.

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 a supportive environment, good team work and their employment at the practice. 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. This included the whistleblowing policy, complaints policy, equality and diversity, confidentiality and safeguarding policies for both vulnerable adults and children. Staff told us they were made aware of any updates in policies and it was their responsibility to ensure they read and understood the policies. They informed us that the senior administrator would check the updates had been read and talked through any questions or concerns staff may have. However, this was not recorded and so senior staff were not able to identify whether all staff had read and understood policies as required.

Staff told us that meetings were held on a regular basis and that issues were discussed amongst staff as they arose. For example, GPs met daily and discussed any complex issues, workload or significant events or complaints. Practice management meetings were held monthly and we were able to review the minutes of these meetings. We saw discussions were had on future training, communication with the patient participation group and patient support programmes.

We were able to see an organisation chart for the practice, which clearly showed the leadership structure for staff. The five partner GPs had all taken on a lead area of responsibility. For example, there were lead roles for infection control, safeguarding and mental health. 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 completed a number of clinical audits. For example, medicine audits ophthalmology referrals and stroke prevention.

Leadership, openness and transparency

Staff we spoke with told us there was an open door culture. They told us that the GPs were approachable, and they were able to approach senior staff about any concerns they had. They said that they felt supported and that there was a good team work within the practice. Staff told us they felt their views and opinions were valued. They told us they were encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients.

There were policies and procedures in place to support staff in their roles and we saw that these were included in the staff handbook, including personal security and infection control. Staff were aware of the whistle blowing policy and a partner GP had taken the lead role in this area to support staff if required. 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.

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

The practice used a number of mechanisms to encourage and obtain patient feedback. This included, through the patient participation group (PPG), through the national GP patient survey and asking for comments through the practice website.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff were encouraged to voice their ideas and opinions about how the services were provided and managed and felt their suggestions were acted on.

Staff told us they attended regular staff meetings and felt confident in raising concerns or questions. Meetings allowed for discussions in relation to changes to

Are services well-led?

Good

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

procedures, clinical practice, and staff cover arrangements. However, reception staff meetings were not recorded. We were told that only the management meetings were recorded, and we saw the minutes from these.

The practice had an active patient participation group (PPG) which was steadily increasing in size. The PPG had carried out a number of surveys and had agreed to six committee meetings per year, plus three open meetings to all patients where health talks were given and an annual general meeting. The practice manager showed us the analysis of the surveys completed and the reports and action plans agreed with the PPG were available on the practice website for patients.

Management lead through learning and improvement

The practice was a GP training practice. We spoke with a GP registrar who told us they were supported in their role. They were able to offer longer appointments for patients and their work was reviewed by their supporting GP. They told us GPs were always available for support and guidance.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff appraisals included personal development plans. Records showed that GPs and nursing staff were supported to access on-going learning to improve their skills and competencies. For example, attending specialist training and opportunities to attend external forums and events to help ensure their continued professional development. For example, a GP had recently attended a two day course for those patients receiving blood thinning medicines.

Administration staff we spoke with told us they were given opportunities to attend courses or training and felt their appraisals gave them opportunities to discuss future training needs. The practice manager informed us that a receptionist had wanted to change roles to that of the healthcare assistant. We spoke with the healthcare assistant who informed us they were encouraged and supported to take on this new role.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The provider failed to ensure that service users were protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user and records in relation to the management of the regulated activity. Regulation 20 (1) (a) (b) (ii)