The Integrated Care Partnership

Quality Report

The Old Cottage Hospital
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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

The practice has an overall rating of good.

We carried out an announced comprehensive inspection at The Integrated Care Partnership on the 7 July 2015. The practice has three branch surgeries and provides personal medical services to over 32,500 patients. We did not inspect any of the branch surgeries. The Integrated Care Partnership is run by a team of 13 partner GPs. The practice is also supported by six salaried GPs, two physician associates, GP registrars, six practice nurses, four healthcare assistants, a team of receptionists, administrative staff, team leaders and a business manager.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It requires improvement for providing safe services, specifically in relation to infection control. We found the practice was delivering a good service to all its population groups.

Our key findings across all the areas we inspected were as follows:

- The practice had a patient participation group that took an active role in developing and improving patient services.
- Patients' needs were assessed and care was planned and delivered in line with best practice guidance.
- Staff had received training appropriate for their roles and any further training needs had been identified and planned.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, reviewed and addressed.
- Risks to patients were assessed and well managed

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Most patients said they found it easy to make an appointment with the GP and that urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice recognised the needs of its older population and had systems in place to support patients through care plans, hospital avoidance schemes and providing extra support for those patients with dementia.

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

Importantly, the provider must:

- Ensure that cleaning equipment is stored appropriately and hygienically and monitor the levels of cleanliness throughout the practice. Ensure that after infection control audits, areas of non-compliance are followed up and action plans created to ensure compliance. Ensure that a risk assessment for legionella is completed.

In addition the provider should:

- Follow-up where staff have failed to complete training in the required timeframe.
- Improve the quality of record keeping, to ensure that actions from significant events and complaints are clearly recorded as having been disseminated to staff.
- Review the recruitment policy to ensure that information required under the Health and Social Care Act – schedule 3 is clearly explained.

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 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. However, we found that cleaning equipment was improperly stored and therefore infection control was inadequate. Staff we spoke with told us they were felt that cleaning standards were poor. The October 2014 infection control audit carried out by the practice highlighted some concerns and there was no evidence that those concerns had been followed up. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. In the event of an emergency the practice had policies and procedures in place to help with the continued running of the service.

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 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 had been identified and appropriate training planned to meet these needs. However, we found that there was not a robust system to ensure that all staff were completing training in a timely manner. There was evidence of appraisals and personal development. The practice worked closely with consultants from the secondary health team who ran clinics from the practice. The GPs used this time to share information, good practice developments and guidelines. The practice also ran a number of in house clinics including cryotherapy, minor surgery, x-ray and ultrasound and physiotherapy.

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

Summary of findings

about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw staff treated patients with kindness, respect and maintained confidentiality. The practice advertised local support groups so that patients could access additional support if required.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they could make an appointment with a named GP or the GP's buddy which ensured continuity of care. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. Patients with disabilities were able to easily access the practice. Home visits were also available.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. The practice manager had retired and the GP Partners had taken on different elements of the role therefore there was a new leadership structure in place. Staff we spoke with told us felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance 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, regular performance reviews and attended staff meetings and events.

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. Patients were made aware of their named GP but could request to see a GP with a specialist interest. For example, diabetes, cardiology or ophthalmology. 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, warfarin (INR) clinics 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. Elderly patients with complex care needs and those at risk of hospital admission had personalised care plans. It was responsive to the needs of older people, and could offer home visits. The practice supported various care homes and residential homes. In 2014 the practice completed a dementia screening project where 418 of their older patients were invited to be screened. The practice held monthly Gold Standard Framework meetings for those patients with end of life care needs. 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 care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medicine needs were being met. The GPs followed national guidance for reviewing all aspects of a patient's long term health. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice nurses were trained and experienced to support patients with managing their conditions and preventing deterioration in their health. Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness. The practice had an in-house dietitian, and ran dietetic education sessions for both diabetic patients and those found to be at risk of developing diabetes.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were slightly higher than average for all standard childhood immunisations. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered contraceptive implants. The premises were suitable for children and babies. Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff. The practice ensured that children needing emergency appointments were seen in a timely manner. Several partner GPs ran a daily surgery at Epsom College for students aged 13 to 18 years of age.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (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. The practice was open from 7:30am until 8pm Monday to Thursday and 7:30am-7pm Fridays. Saturday appointments could also be requested. 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. The practice offered NHS health-checks and nurses were trained to offer smoking cessation advice. Patients could request routine travel immunisations.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with complex health needs. The practice ensured that patients classed as vulnerable had annual health checks. It offered longer appointments for patients when required. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and

how to contact relevant agencies in normal working hours and out of hours. 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. Carers and those patients who had carers were flagged on the practice computer system and were signposted to the local carers support team. The practice had recognised the need for a 'hard to reach' population group to be able to access appointments on the same day. This prevented this group failing to turn up for appointments and enabled the practice to offer opportunistic help and advice. For patients with no fixed abode, the practice could register them at a proxy address at the town hall so that care could still be provided.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients with severe mental health needs had care plans and received annual physical health checks. New cases had rapid access to community mental health teams. There was a weekly session held at the practice by the Samaritans who could offer support. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. A dementia identification scheme had been previously run at the practice. The project involved screening and identified individual patients who were then invited to the practice for screening blood tests and where necessary referred to the memory clinic. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

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 of the practice. We received 30 comment cards which contained positive comments about the practice. We also spoke with 11 patients on the day of the inspection and three members of the Patient Participation Group (PPG).

We reviewed the results of the national patient survey from 2015 which contained the views of 109 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 70% of respondents found it easy to get through to the surgery by phone with the CCG local average being 68%. When asked if they were able to get an appointment to see or speak to someone the last time they tried 88% saying yes, with the CCG local average being 85% and 91% said they had an appointment convenient to them. When asked if the last GP they saw or spoke with was good at giving them enough time 91% said yes and 99% said they had confidence and trust in the last GP they saw or spoke with. All of these scores were above the average for local clinical commissioning group (CCG). When asked if they would recommend the practice 90% said yes with the local average being 79%.

We spoke with 11 patients on the day of the inspection, reviewed 30 comment cards completed by patients in the two weeks before the inspection and spoke with three members of the Patient Participation Group (PPG). The patients we spoke with and the comments we reviewed were positive. Comments about the practice included that patients felt listened to, cared for and respected. Comments also included that staff were friendly, caring and professional. Some of the patients had been registered with the practice for a number of years and we received comments in relation to the support the practice gave to them and their family members. We received five comments from patients who told us they had difficulties phoning through to the practice in the morning. The PPG members we spoke with told us they found the practice responsive and were confident they could influence change when required. They gave examples of how the practice had listened to and acted upon concerns raised.

Areas for improvement

Action the service MUST take to improve

- Ensure that cleaning equipment is stored appropriately and hygienically and monitor the levels of cleanliness throughout the practice. Ensure that after infection control audits, areas of non-compliance are followed-up and action plans created to ensure compliance. Ensure that a risk assessment for legionella is completed.

Action the service SHOULD take to improve

- Follow-up where staff have failed to complete training in the required timeframe.
- Improve the quality of record keeping, to ensure that actions from significant events and complaints are clearly recorded as having been disseminated to staff.
- Review the recruitment policy to ensure that information required under the Health and Social Care Act – schedule 3 is clearly explained.

The Integrated Care Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a Practice Manager, a Practice Nurse and a further CQC inspector.

Background to The Integrated Care Partnership

The Integrated Care Partnership offers personal medical services to the population of Epsom. The practice has three branch surgeries (**Stoneleigh Medical Centre, Fitznells Manor Surgery and Cox Lane Surgery**) which we did not inspect. The practice is involved in the education and training of doctors. There are approximately 32,500 registered patients which are seen at the four different locations.

The Integrated Care Partnership is run by 13 partner GPs. The practice is also supported by six salaried GP, two physician associate, six practice nurses, four healthcare assistants, a team of receptionists, administrative staff, team leaders and a business manager.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and holiday vaccinations and advice.

Services are provided from four location:

The Old Cottage Hospital, Alexandra Road, Epsom, Surrey, KT17 4BL

Open Monday – Friday 7:30am – 7pm and Saturday 9-11am - Late evening appointments Monday to Thursday until 8pm

Stoneleigh Medical Centre 24 The Broadway, Stoneleigh, Surrey KT17 2HU

Open Monday, Tuesday, Thursday, Friday 8am-12pm & 2pm - 9pm & Wednesday 8am - 12pm

Fitznells Manor Surgery, 2 Chessington Road, Ewell, Surrey KT17 1TF

Open Monday, Tuesday, Thursday 8:30am-8pm & Wednesday, Fri 8:60am - 6:60pm

Cox Lane Surgery, Cox Lane, Ewell, Surrey KT19 9PS

Open Monday – Friday 8:30am - 12pm & 2pm - 6pm

We completed a comprehensive inspection for The Old Cottage Hospital only.

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 is a GP training practice and supports new registrar doctors in training. At the time of inspection we were able to talk with one doctor who was receiving general practice training.

The practice population was around average for all age groups when compared to the national and local clinical commissioning group (CCG) average. There are a lower number of patients with a long standing health condition and health related problems in daily life. However there are

slightly higher numbers of people with a caring responsibility and the percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the average for England.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out this comprehensive inspection of the practice, on 7 July 2015, 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. The practice 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 7 July 2015. During our visit we spoke with a range of staff, including GPs, practice nurses, healthcare assistants and administration staff.

We observed staff and patients interaction and talked with 11 patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 30 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 (QOF) data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

Safe track record

We saw that the practice was able to demonstrate a track record for maintaining patient safety. The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events and complaints were discussed at a meeting held every five weeks and a dedicated meeting was held twice a year to review actions from past events. There was evidence that the practice had learned from these but we noted that improvements were needed to the records made, to show how the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the one of the partner GPs. They showed us the system they used to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been discussed. For example, a medication error. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated via email to practice staff and discussed at relevant team meetings. For example, the nurses' monthly team meetings or the practice meetings. 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 also discussed at practice meetings to ensure all 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 vulnerable children, young patients and adults. There were dedicated GP leads for safeguarding children and vulnerable adults. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (Level Three safeguarding children training). Staff 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 leads were and who to speak to if they had a safeguarding concern. We saw that safeguarding contact information was displayed on the front page of the practices in house intranet.

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. The practice only used clinical staff as chaperones. 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. We saw there were posters on display within the clinical rooms and waiting area which displayed information for patients. A patient we spoke with told us that they had in the past requested a chaperone at the time of booking their appointment and had found this service useful.

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.

Requires improvement

Are services safe?

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

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. We looked at daily temperature records of the medicines refrigerators and noted that they were within the required parameters.

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.

Repeat prescription requests and patient medicines reviews were organised in line with the National Prescribing Centre guidance. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice met with the Clinical Commissioning Group (CCG) pharmacists to review prescribing trends and medicines audits.

Vaccines were administered by nurses and the healthcare assistant 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 and the healthcare assistants had received appropriate training to administer vaccines.

Cleanliness and infection control

Patients we spoke with or who had completed comments cards told us they found the practice clean and had no concerns about cleanliness.

The practice employed cleaners who attended the practice daily. The business manager showed us logs which detailed areas required cleaning and how often. There was no evidence that the cleaning was being monitored effectively. We noted that the cleaning equipment was stored unprotected outside the practice and therefore the hygiene of mops then used to clean the practice could not be guaranteed.

There was no lead for infection control with various team members taking on elements of the role. We saw that the practice had undertaken an infection control audit in October 2014. The audit highlighted a number of areas which needed addressing, for example, the practice did not have an annual programme of audit of infection control policies and procedures, staff had not received training in dealing with bodily fluid spills and not all staff had received training in sharps/bites/splash management and were not aware of the actions to take following an injury. The practice was unable to send us an action plan as to how they were going to address the issues found following their audit and a further audit had not taken place.

Many of the staff we spoke with told us they felt the cleaning was inadequate. They told us this was a standing agenda item in some of their meetings. However, there was no evidence that any concerns raised had been followed up by the practice.

After the inspection the practice contacted us to say that they had moved the cleaning equipment to the sluice room within the adjoining day surgery unit. The practice assured us that a central lead for infection control was being reviewed and that concerns raised on the day of the inspection were being quickly addressed.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single-use, and personal protective equipment (PPE), such as aprons and gloves, were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste

and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and the sharps bins were correctly located.

An infection control policy and supporting procedures were available for staff to refer to. This enabled staff to plan and implement measures to control infection.

We spoke with the business manager regarding testing for legionella. The practice had not undertaken a risk assessment to minimise the risk of infection to staff and patients and did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice told us they had contacted an organisation to carry out an assessment but a date had not been organised.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

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 policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, although recruitment files were correct we noted that the policy did not clearly document the information and necessary checks required when recruiting new staff as explained in Schedule 3 of the Health and Social Care Act.

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. 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 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.

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 medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and health and safety information was displayed for staff to refer to. Safety equipment such as fire extinguishers and emergency oxygen were checked and sited appropriately.

We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, we viewed meeting minutes where significant events had been discussed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. GPs we spoke with gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. 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.

We saw that the practice had audited the number of patients who had a flu vaccination due to low figures on their QOF scores for this category. The practice had audited four main categories of patients, those over 65 years of age, under 65 years of age, those patients who were pregnant and at risk and those pregnant but not at risk. We saw that the practice had improved its figures over the last 2 years. Between 2013/14 and 2014/15 figures rose from 60.83% to 65.4% for patients over 65s, from 35.4% to 44% in patients under 65s at risk, from 35.5% to 44.5% for patients who were pregnant but no risk, and 45% to 71.9% for patients who were pregnant with risk.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support, which included the use of the automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). Emergency equipment was available, this included access to oxygen and the AED. When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of telephone systems 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 if the heating system failed.

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. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance were discussed and required actions agreed. 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.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. Patients with specific needs were reviewed to ensure they were receiving appropriate treatment and regular review. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice identified two per cent of patients with complex needs who were at greater risk of admission to hospital as part of a national scheme to reduce avoidable unplanned admissions to hospital. The practice ensured all these patients had a care plan in place. If any of the patients identified were admitted to hospital the GPs followed up their admission. We saw an example of the care plans in place and found them to be comprehensive. It showed us that patients with complex medical needs had a named GP to support continuity of care.

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 and they were referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

The practice had piloted a Physician Associates (PA) project and had employed two PAs to address urgent care alongside two GPs. (PAs are dependent health care professionals who have been trained in the medical model and work with supervision of a doctor). Patients calling for an on the day emergency appointment were able to be seen by the PA. The PAs were able to conduct physical examinations, diagnose and treat illnesses, order tests and interpret results and counsel on preventive health care.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved. For example, following guidance from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding medicines used for anaphylaxis treatment a clinical audit was carried out in May 2015. The MHRA recommended that patients were reviewed to ensure they had the correct dosage and that patients had two devices on them at all times. The aim

of the audit was to ensure that all patients prescribed this medicine were on the correct dosage, that the medicine was still in date and that patients had two devices prescribed. The audit demonstrated that from 88 patients, nine did not have two devices, 18 had out of date medication and ten patients needed to have their dosage reviewed. A second clinical audit was recommended for one years' time and this learning had been shared with all staff to which it was relevant.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 96% of patients with diabetes had received the flu jab and 93% had a record of retina screening preceding 12 months. We also noted that 91% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional; including an assessment of breathlessness in the preceding 12 months and that 100% of patients aged 75 or over with a fragility fracture, were currently being treated with an appropriate bone-sparing agent. We also noted 73% of asthma patients, on the register, had an asthma review in the preceding 12 months that included an assessment of asthma control. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. 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.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice had made use of the gold standards framework for end of life care. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. For example, patients who were most likely to be subject to unplanned hospital admissions. Structured annual reviews were also undertaken for these patients and those with long term conditions such as chronic obstructive pulmonary disease (COPD) and heart failure. The QOF data showed good performance in all of these areas. Patients were also highlighted on the practice computer system so that their care could be prioritised.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support, safeguarding children and vulnerable adults. We noted a good skill mix among the doctors with some having additional diplomas in obstetrics and gynaecology, child health and ophthalmology. 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 undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff we spoke with told us they felt their appraisal was effective and a positive experience. Our interviews with

Good

Are services effective?

(for example, treatment is effective)

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. We received positive feedback from the trainees we spoke with. We noted that registrars were supported by six of the GP partners were had been trained to take on the role as trainer.

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 and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. 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. Relevant staff were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Out of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day received. Discharge summaries and letters from outpatients were seen and actioned usually on the day of receipt and all within five days. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles. We noted that any important information that needed to be read and or actioned by staff was disseminated on e-mails with pink backgrounds. All staff we spoke with were all aware of the importance of these mails.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. We noted that the practice held monthly palliative care meetings. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented. Staff felt the system worked well and staff remarked on the usefulness of the forum as a means of sharing important information.

The practice worked closely with consultants from the secondary health team who ran clinics from the practice. The GPs used this time to share information, good practice developments and guidelines. The practice also ran a number of in house clinics including cryotherapy, minor surgery, x-ray and ultrasound and physiotherapy. Several partner GPs ran a daily surgery at Epsom College for students aged 13 to 18 years of age.

The GPs ran a buddy system. This meant that the GPs buddy would cover their work if the GP was on leave, training or off sick. If a patients' GP was not working patients would be offered an appointment with the buddy. This helped to ensure there was a continuity of care between two GPs for patients.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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 saw that the practice had a consent policy. Staff we spoke with were able to give examples of how they obtained consent. We saw there were consent forms for

Good

Are services effective?

(for example, treatment is effective)

patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their responsibility in respect of consent prior to giving care and treatment. They described the procedures they would follow where patients lacked capacity to make an informed decision about their treatment and gave us examples of how the patient's best interest was taken into account and recorded in their personal notes.

The clinicians we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Patients with more complex needs, for example dementia or long term conditions, were supported to make decisions through the use of care plans, which they were involved in agreeing. There was evidence that care plans were appropriately reviewed and that they contained details of the patient's references for treatment and decisions. Data we reviewed showed that 88% of patients diagnosed with dementia had their care reviewed in a face-to-face review in the preceding 12 months with the national average being 83% and 94% of patients with a diagnosis of depression had a care review between ten and 35 days after their diagnosis with the national average being 78%.

Health promotion and prevention

We saw that people had access to a range of information leaflets and posters in the waiting room about the practice and promoting good health. Information about how to access other healthcare services was also displayed. This helped patients access the services they needed and promoted their welfare. Health information was also made available during consultation and GPs used materials available from online services to support the advice they gave patients

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of patients with poor mental health and 100% had seen a GP for an annual review and had a comprehensive care plan agreed.

The practice had identified the smoking status of 85% of patients over the age of 15 and we noted that 92% of those patients recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months. Data from QOF also showed that 90% of female patients who were prescribed an oral or patch contraceptive method in the last 12 months had also received relevant information about long acting reversible contraception. We noted that 96% of patients diagnosed with diabetes had received their flu immunisation.

The practice offered all new patients registering with the practice and patients aged 40-75 years old a health check. The practice offered a full range of immunisations for children in line with the Healthy Child Programme. The practice's performance for cervical smear uptake was 81%, which was on par with the national average. We noted that there was a mechanism in place to follow up patients who did not attend screening programmes.

Family planning services were provided by the practice. The practice nurses and some GPs were trained in performing cervical smears. The practice nurses offered healthy living advice and support to patients. The practice had access to an in-house dietitian and ran dietetic education sessions for diabetic patients and those found to be at risk of developing diabetes.

All patients with a learning disability were offered an annual physical health check. Flu vaccination was offered to all patients over the age of 65, those in at risk groups and pregnant women. The shingles vaccination was offered according to national guidance for older people.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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 92% 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 90% of practice respondents saying the GP was good at listening to them and 88% saying the same about the nurses. When asked if the last GP or nurses they saw or spoke to was good at giving them enough time 89% agreed for both the GPs and nurses did. We also noted that 99% of patients had responded that they had confidence and trust in the last GP they saw or spoke to and 98% said the same about the last nurse they saw

We also spoke with 11 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. Patients said they felt the practice offered an efficient service and staff were friendly, considerate and caring. They said staff treated them with dignity and respect. Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 completed cards and all but one were positive about the service experienced

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains / 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 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. The practice main switchboard was located away from the reception desk and patients waited for their appointments in a separate waiting area. This helped to prevent patients overhearing potentially private conversations between patients and reception staff. We noted that music was played in the waiting areas and patients were able to book in using an electronic booking in system which also allowed for a patient confidentiality. Staff were able to describe practical ways in which they helped to ensure patient confidentiality. This included not having patient information on view and asking patients if they would like to speak in a private room away from the front desk, if required.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. We noted that some reception staff had received training in conflict resolution.

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 86% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were slightly higher when compared to the clinical commissioning group area where results were 83% and 87% respectively.

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

The practice participated in the avoidance of unplanned admissions scheme. There were regular meetings to discuss patients on the scheme to ensure all care plans were regularly reviewed.

We noted that the practice's QOF performance of 100% was above the national average for the percentage of patients with schizophrenia, bipolar affective disorder and other

psychoses who had a documented comprehensive care plan on file, agreed between individuals, their family and/or carers as appropriate, with the national average being at 86%.

Staff told us that interpretation services were available for patients who did not have English as a first language including British Sign Language. A hearing loop was also available for those patients with hearing difficulties.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 89% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 93% of patients said the nurses were also good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Leaflets in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We noted an information board in the waiting area which contained information for carers to ensure they understood the various avenues of support available to them. The business manager informed us that the Samaritans were available at the practice weekly and patients could book an appointment to speak to someone in confidence. We saw leaflets in the patient waiting areas advertising this service.

We also looked at care provided for patients diagnosed with depression. We noted that the practice's QOF performance showed that 83% of patients with a new diagnosis of depression had a review not later than the target 35 days after diagnosis. This was higher than the England practice average of 78%.

Staff told us that if families had suffered bereavement, their GP would contact them. Staff could also arrange a patient consultation at a flexible time and would give them advice on how to find support services.

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 people's 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 in the way services were delivered. For example, the practice had recognised the need for a hard to reach population group to be able to access appointments on the same day. This prevented this group failing to turn up for appointments and enabled opportunistic advice to be given to help maintain or improve mental, physical health and wellbeing.

Patients were able to book appointments on the day or up to four weeks in advance and home visits could be requested when necessary. We also saw that the practice ran a duty doctor rota. The duty doctors' role was to ensure that patients were triaged and if needed seen in an emergency on the same day either by the duty GP or the physician associate. Longer appointments were available for patients who needed them and for those with long term conditions. Patients were able to book appointments and order repeat prescriptions on line.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice had received comments that patients sometimes waited a long time for calls to be answered during peak times of the day. In response to this the practice had increased the number of phone lines and had dedicated staff to answer calls.

The practice supported patients with complex needs and those who were at risk of hospital admission. These patients were given a dedicated bypass telephone number so that their care could be prioritised. The practice worked closely with district nurses, health visitors and the palliative care team. Personalised care plans were produced and were used to support patients. The practice had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Patients with long term condition had their health reviewed in an annual review. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health. Childhood immunisation services were provided through dedicated clinics and administrative support to ensure effective follow up.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from 2015 confirmed this with 91% of patients stating the doctor gave them enough time and 91% stating they had sufficient time with the nurse. These results were mostly in line with the national averages (88% and 93% respectively).

The practice ran a number of in house services including ultrasound, x-ray, uroflowmetry and bladder scanning, as well as ECG, spirometry and dietetic education sessions. There were also a number of secondary care clinics that were run by consultants from the practice with support from some of the GPs with special interests in these areas. For example, paediatric, gynaecology and ophthalmology services.

Referrals were made via the patients GP and the practice had an administrative team in house to deal with these referrals in a timely manner.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. 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 practice website also had the functionality to translate the practice information into 90 different languages and change the font size for those with a visual impairment. The practice had a hearing loop for those patients with hearing impairments.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated over three floors, with the top floor being for staff only. There was a lift which allowed access for patients to the first floor. We noted patients had access to the front entrance of the practice via a slope and doors which had an automatic opening mechanism. Patients with restricted mobility could easily enter the practice. The waiting area was accessible for wheelchairs and mobility scooters. Accessible toilets were available for all patients attending the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

Staff told us that they any patients who were of "no fixed abode" would be given an appointment if they came to the practice asking to be seen. The practice had arrangements where they could register 'no fixed abode' patients at a proxy address at the town so they could access services. There was a system for flagging vulnerability in individual patient records. Staff told us that the practice offered extended appointments for patients who needed them. The practice also used a computer programme to alert staff to book longer appointments for reviews of patients with certain medical conditions such as asthma or diabetes.

Access to the service

The surgery was open Monday to Friday 7:30am to 7pm. The practice had late evening appointments on Mondays to Thursdays until 8pm, there were also Saturday morning bookable appointments from 9am to 11pm. Patients could book appointments up to four weeks in advance, with a number of appointments available on the day for patients. The practice operated a daily urgent care appointment system where the duty doctor could offer telephone triage and if necessary the patient could have an appointment with the duty GP or the physician associate. (A Physician Associate is a healthcare professional licensed in the UK to practice medicine with doctor supervision).

Comprehensive information was available to patients about appointments on the practice website and through a practice leaflet. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. Patients we spoke with confirmed that they could a see a doctor on the same day if they needed to. They told us they had been able to get appointments at a time convenient to them. Staff told us longer appointments were also available for patients who needed them for example, those with long-term conditions.

On the day of inspection we asked staff when the next available appointment would be for an appointment for a cervical screening test and a pre-bookable appointment with a specific GP. We were given an appointment for the cervical screening later the same day. The first available pre-bookable slot for the GP was in one weeks' time. The receptionist did inform us that we could book a triage appointment if we wanted to speak to a GP rather than wait.

We noted data from the national patient survey 2015 indicated that 70% of patients thought it was easy to get through to the practice by phone which was on par with the national average for the clinical commissioning group area of 68% and 91% of respondents said the last appointment they received was convenient**.**

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. This was in a complaints leaflet and on their website.

We asked several patients if they had ever needed to make a complaint about the practice. Only one replied they had and had been unhappy with the way it was handled as they had been unable to speak with the complaints lead and had therefore not continued with the complaint. We raised this with the Business Manager who reassured us that all reception staff were aware of the process to follow and welcomed patients raising concerns so that they could seek to improve aspects of their service where patients felt they may be underperforming.

We looked at several complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency in dealing with the compliant. If the complainant was not happy with how the complaint had been resolved there were details of who else they could contact. The practice reviewed complaints received once a month and also held meetings twice a year to detect themes or trends. We saw that where necessary protocols had been changed to

Good

Are services responsive to people's needs?

(for example, to feedback?)

ensure that lessons were learned from individual complaints. For example, we saw that a new death protocol had been put in place after a complaint in relation to miscommunication.

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 had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values in their statement of purpose. The practice vision and values included to provide excellent 'One-Stop' healthcare to all patients. The vision also included a focus on providing accessible care in the most suitable surroundings, To provide continuous care that is responsive to the needs of all the patients and to create opportunities and incentives for primary care professionals and employees and fully utilise their skills and competencies with the Integrated Care Partnership.

We spoke with 14 members of staff and they all knew and understood the vision and values 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 a 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 on the desktop on any computer within the practice. We looked at some of these policies and procedures and found these had been reviewed on a regular basis, were up to date and contained relevant information for staff to follow. This included medicine management, whistleblowing, complaints, chaperoning and infection control.

The practice had recently gone through a period of restructuring due to key members of staff leaving or retiring from the practice. This included the practice manager and the GP partners had taken on elements of this role. We reviewed a team management structure which showed the division of the administrative tasks and clinical tasks split between the 13 partners. For example, there were different leads for complaints, the nursing team and for safeguarding. We spoke with 14 members of staff who, although this was in its infancy, felt that the split of the practice managers' roles with the partners would mean the partners would have a greater understanding of their specific jobs. However, when we asked who the lead role was for infection control we found that the different elements had been split between different staff members and there was no single person taking responsibility. We discussed this with the practice as we had found concerns in relation to infection control. After the inspection we were re-assured that the concerns were being addressed by one of the partners and that the partnership was in the process of allocating a single infection control lead who would take on full responsibility. The three board members of the patient participation group we spoke with, told us they were monitoring very closely how not having an individual practice manager effected the running of the practice and were looking at the individual roles of the partners to ensure that services were still well run and effective.

Staff we spoke with were all clear about their own roles and responsibilities and knew who to report to for any issues. They all told us they felt valued and well supported.

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 minor operations, thyroid-stimulating hormone TSH checks for patients with hypothyroidism and patients who require anaphylaxis shock medication.

The practice had arrangements for identifying, recording and managing risks. The business manager showed us risk assessments, which addressed a wide range of potential issues, such as IT systems, facilities management, update of protocols and fire.

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. QOF data was discussed at monthly team meetings to maintain or improve outcomes.

The practice held regular meetings. We looked at minutes from the most recent meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at 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. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient and staff satisfaction

Are services well-led?

Good

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

and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the Clinical Commissioning Group.

Leadership, openness and transparency

The partners in the practice were visible and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held on a regular basis. For example, there were monthly nursing team meetings, weekly partner meetings and monthly team leader meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so. We also noted that team away days were held. Staff said they felt respected, valued and supported.

The practice had a protocol for whistleblowing. Staff told us they knew it was their responsibility to report anything of concern and knew the practice and senior team members would take their concerns seriously and support them. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff we spoke with thought the culture within the practice was open and honest.

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

The practice had an active patient participation group (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). There were currently 12 patients who were board members of the PPG and around 30 to 40 patients who attended focus group meetings. On the day of the inspection we were able to speak with three board members of the PPG who told they felt that the practice was responsive to any issues raised by the group. They told us that they held regular meetings every six weeks including an Annual General Meeting in April. In between these meetings the group communicated via email, the practice notice boards and the practice web site. The practice had arranged for the board members to be trained in running focus groups and these were run at least twice a year. The PPG supported and advised the practice in areas such as, monitoring access to appointments, the on-line booking system, and helped to create action plans from patient surveys or concerns raised.

NHS England guidance states that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test, (this is an opportunity for patients to provide feedback on their experience which can be used to improve services). We saw the practice had introduced the Friends and Family Test and there were questionnaires available at the reception desk and instructions for patients on how to give feedback.

The practice had also gathered feedback from staff through a staff survey, staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

The practice placed a strong emphasis on continuous professional development for all staff. The practice was a training practice for GPs and the feedback from the registrar we spoke with was positive. The practice worked well together as a team and held monthly education meetings for team learning and to share information. For example, we saw that in January 2015 an education meeting was held on diabetes and in February smoking cessations. Future meetings were planned for guest speaker to attend including from Surrey Heart Cardiac Rehabilitation Service in August.

We saw the practice used a range of meetings to learn and improve the way the practice was run. We saw evidence that meeting we held to discuss patients using the Gold Standards Framework. The GPs spent time with consultants within the secondary care clinics to ensure their continued learning of best practice. 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 and staff.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training. Staff had access to a

Are services well-led?

Good

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

programme of induction and continuing developmental training. Mandatory training was undertaken; however we noted that this was not always monitored to ensure staff were accessing training within the time frames required.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections. This was due to inappropriate and unhygienic storage of cleaning items, not actioning non-compliance found after infection control audits or assessing the risk from legionella bacteria. This was in breach of regulation 12(2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.