

Gray's Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	10
Areas for improvement	10

Detailed findings from this inspection

Our inspection team	11
Background to Gray's Medical Centre	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Gray's Medical Centre on 2nd June 2015.

We found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people including those recently retired and students, people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

Our key inspection findings were as follows:

- There were comprehensive systems in place to ensure the delivery of safe care including safeguarding processes, health and safety assessments and equipment to deal with emergencies.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. The practice adapted a learning approach to significant events such that incidents were investigated and any outcomes were used to improve patient care.

- The practice had actively reviewed its patient population so that services could be targeted to meet the needs of its patient population.
- Patients reported that there had been improvement in both access to appointments and delivery of care in the past six months.
- Multidisciplinary meetings were carried out and information was shared with a range of different services to ensure continuity of care for patients.
- Patients' needs were assessed and care was planned and delivered following best practice guidance ensuring patient-centred care was provided
- Information about services and how to complain was available and easy to understand.
- There were a number of policies and procedures available to govern activity and these were updated regularly
- Staff felt well-supported by the practice team and felt able to raise any concerns

Summary of findings

- Although information was shared within the practice, there were not always good communication links to cascade information from the provider organisation to all staff

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

In addition the provider should:

- Ensure that all patient group directions (PGDs) are updated in line with recognised guidance.
- Ensure that there is a robust system in place to consistently record and monitor vaccine refrigerator temperatures.
- Ensure that a developed system of audit is continued in the practice.
- Ensure that a patient participation group is set up to assist in improving services.
- Ensure that online prescriptions and appointments are available in line with contractual obligations.
- Ensure that staff and patients are able to clearly differentiate between the general practice and walk in centre services that are provided within the same building. This includes ensuring that governance systems are in place to ensure that delivery of the walk in service does not impact on the care provided to the Gray's practice. It should also include regular review of the sufficiency of staffing at both practices.
- Ensure that it is clear who has the role of strategic lead in the practice.

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?

The practice is rated as good for providing safe services. There were a wide range of policies and protocols in place to ensure a safe track record, and incidents and significant events were recorded, investigated and reviewed.

Safety systems in the practice were reliable and there were clinical leads where required, such as for safeguarding. Significant event analysis at the practice was well developed. Staff at the practice demonstrated they were aware of their roles and responsibilities for safeguarding and chaperoning duties, and staff training was up to date.

Appropriate medicines management systems were in place at the practice, and the practice had effective infection control procedures in place. The practice was noted to be clean. Storage of medicines and vaccines was appropriate, although vaccine refrigerator temperatures were not always consistently recorded. Clinical equipment was well maintained and serviced regularly.

Staffing levels in the practice were adequate and recruitment policies and procedures were fit for purpose. There were thorough risk management processes in the practice and a business continuity plan was in place. The practice was well equipped to deal with emergencies on site.

Good



Are services effective?

The practice is rated as good for providing effective services. There were regular meetings where provision of effective care was discussed, including the implementation of new guidelines. Quality and Outcomes Framework (QOF) and patient records reviewed showed mainly good outcomes for patients. The practice had implemented some effective health promotion and preventative care, however uptake for seasonal flu immunisations for all patients entitled to them was below both national and CCG averages.

Audits in the practice were in place and were demonstrated improved levels of service for patients. However, the audits reviewed were mostly instigated in response to issues having been raised by patients or practice staff, rather than a proactive cycle of learning. The practice engaged with health care providers in the community and with the local Clinical Commissioning Group (CCG). All staff were supported in their continuing professional development and clinical staff kept up to date with best practice and guidelines, with updated guidance being discussed in clinical meetings, including updates from the National Institute for Health and Care Excellence (NICE).

Good



Summary of findings

The practice offered regular reviews for patients with long term conditions and there were nurse led clinics for management of diabetes and asthma.

Are services caring?

The practice is rated as good for providing caring services.

The patients and carers we spoke to said that the service being delivered had improved, although some stated that in the past services had not been adequate. They said that they felt well cared for and were involved in care and treatment decisions. We observed that staff treated patients with respect, dignity and empathy. Patients said that they were happy with the standard of service provided by the practice.

The practice had implemented care plans for patients where required and were proactively looking to meet with all housebound patients to determine whether or not a formal care plan would be of benefit. Confidentiality at the practice was well maintained.

However, patient feedback from a survey published in January 2015 showed results patients felt less involved in their own care by doctors than the national average. It also reported a lower than average satisfaction with how caring administrative staff were at the practice. The practice had implemented an action plan to address a number of these points, and based on the feedback from service users elicited during the inspection, they had been to a degree successful in doing so.

Good



Are services responsive to people's needs?

The practice is rated as good at being responsive to patients' needs.

The practice understood its population demographics and had taken active steps to develop services for their patients. A large number of patients were those of working age and the practice offered extended hours to accommodate these patients. They had also recently increased the number of telephone consultations offered. The practice were responsive to the needs of older people who formed a higher than average proportion of the practice population. These patients had a named GP and the practice was proactively visiting housebound patients to determine whether or not they required a care plan

The practice offered a combination of same day and pre-bookable appointments. Clinics were in place for long term conditions such as diabetes. The practice also provided extended appointments for patients with complex needs including those with learning difficulties. All clinical areas of the practice were accessible to all patients.

Good



Summary of findings

The practice had systems in place to learn from patient feedback. Changes had been made following a patient survey and patients had noted an improvement in the service being provided.

The practice did not have a patient participation group (PPG) at the time of the visit but they were actively involved in organising it. The practice had tried to start a PPG a year ago but at that time they had not been successful in doing so. In discussion with the practice manager it was clear that patient participation would play an important part of shaping the practice moving forward.

Are services well-led?

The practice is rated as good for being well led.

Governance arrangements in the practice were in some cases appropriate and a range of suitable policies and procedures were in place. However, the lack of separation of systems between the practice and adjacent walk in centre could potentially be detrimental to patients at the practice. Regular meetings took place with various staff members and actions following meetings were clearly documented.

Leadership roles had been implemented for a number of clinical areas such as safeguarding and staff were aware who to report concerns to. However, there was lack of clarity regarding the leadership role in the practice, particularly in relation to developing services for the future.

Staff reported that they felt engaged with the managers in the practice and that they were supported for their personal development. However, staff also reported that the boundaries between the practice and the walk in centre being provided at the premises were blurred.

At the time of the visit a patient participation group (PPG) was not in place. Although a formal PPG had not been established the practice had gathered feedback from patient surveys.

Good



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

The practice is rated as good for the care of older people.

The practice was responsive to the needs of older patients. Regular multi-disciplinary team meetings took place at the practice with other health providers in the community to ensure that there was integrated care. All patients 75 years of age and over had a named GP and could access urgent daily appointments where required. Telephone appointments were also available for those patients who were not able to attend the practice.

The practice had systems in place to ensure that regular medication reviews were completed for patients. The practice provided a proactive health check service for housebound patients and implemented care plans where required, and this was on-going at the time of the inspection. The practice also ensured that each patient on the avoiding unplanned admission register had a care plan in place.

The practice provided flu vaccinations to patients over 65 either at the practice in conjunction with community healthcare providers.

Good



People with long term conditions

The practice is rated as good for the care provided to people with long term conditions.

The care of patients with long term conditions such as diabetes was provided by both GPs and nurses in the practice. Records for patients with long term conditions were identifiable on the practice database and flags were in place to ensure that review dates were not missed.

GPs and nurses reviewed care in clinical meetings and meetings took place where necessary with other health care providers to ensure a multi-disciplinary approach to the care being provided. Annual reviews were carried out for patients with long term conditions. Care plans were completed and those patients with care plans were able speak to a GP within 24 hours.

Blood tests were available at the practice which was more convenient for patients. Where patients were newly diagnosed, further information to advise patients how to manage their condition was proactively provided by clinical staff. This provision of information was to help avoid unplanned hospital admissions by improved patient self-management.

Good



Summary of findings

Families, children and young people

The practice is rated as good for the care of families, children and young people.

Appointments were available in the practice both pre-bookable and on the day and access for families, children and young people was adequate. Appropriate referral systems were in place to ensure ante-natal care both in hospitals and in community care. Baby changing facilities were in place in the patient toilet in the practice.

All staff in the practice had completed safeguarding training to the required level, and there were suitable safeguarding policies in place. Notices detailing safeguarding contacts were in all of the clinical rooms in the practice, and in the reception area. There was a nominated safeguarding lead in the practice as well as nominated deputy in the absence of the lead. There was clear communication with other healthcare professionals including health visitors. Young people who were subject to child protection were read coded in the clinical system and patient alerts flagged on their record when entering the patient record.

Child immunisations were provided at the practice and uptake was in line with national averages. The whooping cough vaccine (Pertussis) was offered to all women who were 28 weeks pregnant or over.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

Pre-bookable and same day appointments were available with GPs, and the practice offered telephone appointments for those who worked a distance away for the practice. Formal extended hours were available twice a week, although informally (due to the walk in centre) all patients could see a doctor in the practice until 8 o'clock any evening. The practice had recently increased the number of daily telephone appointments to meet the needs of working age patients. At the time of the visit online prescription and appointment access were not available, however were shown that the practice was implementing this within the next month.

The practice offered both in house blood testing and electrocardiogram (ECG) services providing greater convenience to patients at the practice.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



Summary of findings

The practice had a thorough set of risk assessments in place. Policies for the safeguarding of both children and vulnerable adults were in place, and staff were aware of the procedures for managing any issues arising. Chaperoning services were available at the practice, and there were prominent notices in both clinical rooms and the waiting area advertising this.

One member of staff had been trained formally in the Mental Capacity Act (MCA), and they had trained the rest of the practice team. All of the clinical staff detailed a full understand of the application of the MCA, and knew what actions were required. Non-clinical staff understood some of the basic principles of the MCA, but several staff were not aware of the practice policy relating to it. Extended appointments were available to patients with learning disabilities.

The practice manager confirmed that registration systems were in place for all potential service users including those in the traveller community and homeless patients who may have difficulty providing a proof of address that is normally required.

The practice clinical staff held regular clinical meetings with district nurses and health visitors to discuss care and treatment for patients who were at risk and deemed vulnerable.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Patients on the mental health register at the practice had annual reviews which included review of their needs and medications. Those patients with care plans had been allocated a specific GP which allowed the patient to speak to that GP within 24 hours. The practice was signed up to the dementia local enhanced service (DES) which aimed to improve timely diagnosis and signposting to support services, although no data was provided as to the efficacy of this service. A review of patient records showed that patients with dementia and mental health issues were receiving regular reviews.

The community mental health team were invited to the monthly multi-disciplinary team meetings, and any at risk patients were discussed at these meetings. Contact details for support workers and carers were recorded in the patients' notes and these details were checked with the patients during consultations.

Good



Summary of findings

What people who use the service say

We spoke with eight patients during our inspection and we received three Care Quality Commission (CQC) comment cards completed by patients who attended the practice during the two weeks prior to our inspection.

The eight patients we spoke to told us that the practice had improved in recent months and that they were happy with the recent care that had been provided. The majority of the patients who we spoke with said that they were treated with respect and dignity.

Two of the patients reported that getting an appointment could be difficult, and two others stated that this had been a problem in the past but that there had been a significant improvement recently. In general terms the patients we spoke to said that they were happy with their GP and felt that they were included in decisions about their care.

The three comment cards reflected similar themes to those of patients to whom we spoke. One stated that the patient and their partner had been registered at the practice for a number of years and were very satisfied with the care provided, commenting that it was the best surgery they had been to. Another said that obtaining appointments could be very difficult. One comment card reported that in the past staff had been unhelpful, but again, an improvement in care had been made recently. The patient also noted that they saw many different doctors and as such did not receive continuity of care.

The national GP patient survey of published in 2015 showed the practice to be below the national average in a number of areas. Of particular note was that only 49% rated their experience at the practice as good, compared to the national average of 68%. Other areas of note included:

- 53% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care compared with the national average of 75%.
- 62% said they found the receptionists at the surgery helpful compared with the national average of 87%.
- 69% said the last GP they saw or spoke to was good at listening to them compared with the national average of 87%.
- 69% said the last GP they saw or spoke to was good at explaining tests and treatments compared with the national average is 82%

However, the scores for the quality of nursing care in the practice were in line with national averages. Of particular note, 85% of patients had confidence and trust in the last nurse they saw or spoke to, the same as the national average.

The practice did not have an active practice participation group (PPG) at the time of the inspection.

Areas for improvement

Action the service **SHOULD** take to improve

- Ensure that all patient group directions (PGDs) are updated in line with recognised guidance.
- Ensure that there is a robust system in place to consistently record and monitor vaccine refrigerator temperatures.
- Ensure that a developed system of audit is continued in the practice.
- Ensure that a patient participation group is set up to assist in improving services.
- Ensure that online prescriptions and appointments are available in line with contractual obligations.
- Ensure that staff and patients are able to clearly differentiate between the general practice and walk in centre services that are provided within the same building. This includes ensuring that governance systems are in place to ensure that delivery of the walk in service does not impact on the care provided to the Gray's practice. It should also include regular review of the sufficiency of staffing at both practices.
- Ensure that it is clear who has the role of strategic lead in the practice.

Gray's Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector, a CQC inspector, a GP specialist advisor and an expert by experience. The inspection team members were granted the same authority to enter the practice as the CQC lead Inspector.

The inspection took place over one day, and we looked at care records, spoke with patients, a patient representative who was assisting the practice in setting up a patient participation group (PPG), and staff including the GPs at the practice and the management team, both those who work locally and senior staff from Malling Health.

Background to Gray's Medical Centre

Grays Medical Centre is located in Chessington in the London Borough of Kingston in South-West London. The practice is operated by a corporate provider, Malling Health, who operate a number of GP practices across England. The medical centre shares the premises with a walk in centre which is also operated by Malling Health. The practice provides services to approximately 2,300 patients, and serves a range of patients. The practice has a higher than average population of those aged between 45 and 79. The practice operates in an area where life expectancy is higher than the national average.

The staff in the practice work are employed by both Malling Health services on site. All staff had contracts which included a breakdown of hours worked for each of the services. This was to ensure that there were always

sufficient staff on site to meet the needs of both services. Three part time salaried general practitioners work at the practice, with one of them acting as the clinical lead GP. The practice also utilises locum GPs, some of whom work for Malling Health across a number of sites that they operate, with others that are employed through a locum agency. Of the three salaried GPs, one is male and two are female. The practice also employs three nurses, a phlebotomist, nine reception and administrative staff, a practice manager and an assistant practice manager.

The practice is contracted by NHS England for general medical services (GMS) and is registered with the Care Quality Commission (CQC) for the following regulated activities: treatment of disease, disorder or injury, maternity and midwifery services, surgical procedures, family planning services, and diagnostic and screening procedures at one location.

The practice provides a range of essential, enhanced and additional services including extended hours access, the learning disabilities health check scheme, sexual health, and facilitating timely diagnosis and support for dementia.

The practice is open five days a week from 8:00am to 6:30pm on Mondays, Wednesdays and Thursdays; from 8:00am to 7:30pm on Tuesdays and 8:00am to 7:00pm on Fridays. Out of hours services for the practice are provided in partnership with an external agency when the surgery is closed. However, as the walk in practice in the same building is operated in parallel by the same staff, it was reported that patients in the practice could see their own GP until 8:00pm any evening.

The practice moved to its current location two years ago from an adjacent building. Although not a purpose built building it has been extensively renovated for clinical use. The practice is well decorated and all areas were noted on the day of the inspection to be clean and bright. The practice has appropriate facilities and access for all

Detailed findings

patients, including for wheelchair users. All of the clinical rooms in the practice are on the ground floor. There are three consulting rooms, two treatment rooms and a small room used by the phlebotomist. There is also a combined reception and waiting area at the premises. The upper floor contains a number of staff offices, plus other staff areas which are all only accessible by keypad. Parking is limited outside the practice as it is a converted residential building, but one disabled parking place is available, as is on street parking.

Why we carried out this inspection

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

From April 2015, the regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England and Kingston Clinical Commissioning Group (CCG) to share information about the service. We carried out an announced visit on 2 June 2015. During our visit we spoke with patients and a range of staff which included GPs, practice manager, nurse, and receptionists. We looked at care records, and spoke with the management team. We spoke with eight patients who used the service, and received comment cards from a further three service users. We also observed how staff in the practice interacted with patients in the waiting area.

As part of the inspection we reviewed policies and procedures and looked at how these worked in the practice.

Are services safe?

Our findings

Safe track record

The practice demonstrated that it had a good track record for maintaining patient safety. The practice manager explained that there were clinical meetings on a fortnightly basis where standing agenda items included any significant events. Minutes of the meetings showed that individual significant events had been discussed and action plans to address risk had been developed, with review dates. Arrangements were in place in the practice to ensure that safety alerts from third party organisations were cascaded to the relevant clinical staff in the practice. Not all of the administrative staff in the practice were aware of the exact details of policies in place for managing patient safety alerts.

Learning and improvement from safety incidents

The practice had an effective system in place for reporting, recording and monitoring incidents and significant events. There were clear systems in place for reporting, recording, monitoring and taking action in relation to significant events. There was also evidence of changes to practice policies following clinical incidents. An example of this was that a patient had been given a vaccination without a check of allergies having first been carried out. The practice had been open in raising this with the patient, and following the incident had implemented systems to improve recording of allergies within the patient record. There was also evidence that audits had been carried out following serious incidents to identify potential impact on patients. In total, eight significant events, which had taken place within the last 12 months, were reviewed by the inspection team during the visit. In all cases, escalation, review, discussion and improvements to the service in response were evident. Where necessary learning points had been shared with both clinical and non-clinical staff both by e-mail and in practice meetings.

The practice had a risk register for clinical events with review dates as necessary. Non-clinical risks in the practice were managed appropriately with actions taken where necessary.

Reliable safety systems and processes including safeguarding

The practice had reliable systems in place to ensure safety, including safeguarding of vulnerable adults and children. One of the three salaried GPs (who worked for the practice three days per week) was the lead for safeguarding, and all staff we spoke to knew to escalate concerns to the safeguarding lead. In cases where the safeguarding lead was not at the practice, one of the other GPs in the practice deputised. Policies were in place for both child and vulnerable adults detailing all actions required by staff. Members of staff, both clinical and non-clinical, were aware of their responsibilities in line with this policy. All staff in the practice had received the appropriate level of child protection training; GPs were trained to level 3, Nurses were trained to level 2 and reception and administrative staff to level 1. There were contact numbers displayed in each of the consultation rooms with details of organisations and individuals. This included details of the local safeguarding departments for both children and vulnerable adults.

Clinical staff and some of the more recent administrative staff in the practice had received the Disclosure Barring Service (DBS) check. Some longer standing members of staff, including those who acted as chaperones, were not DBS checked, although risk assessments had been carried out where they were not. The practice manager stated that policy had recently changed and within the next month all staff would be DBS checked. All of the staff in the practice who acted as chaperones had received training, and an up to date policy was in place. In each of the clinical rooms in the practice and reception, there were prominent notices in relation to the availability of chaperones if required.

All staff who acted as chaperones in the practice had received the appropriate training and they were able to describe what their role was when acting in this capacity.

Medicines management

Appropriate medicines management systems were in place in the practice. Medicines and vaccines were safely stored and disposed of in accordance with the relevant guidelines. They were checked regularly to ensure that they had not expired. Recording of medicines was also appropriate. Anaphylaxis (emergency medicine) kits were available in each of the treatment rooms, the correct medicines were present and they were in date.

Vaccines were kept in appropriate refrigerators in the practice. The temperature recording log book for the refrigerator was completed in the large majority of

Are services safe?

incidences, but there were three days where it had either not been checked or the reading had not been recorded. The practice manager reported that a new system had put in place following this to ensure that the first receptionist in every morning checked the temperatures on days when the nurse was away from the practice. Where recorded, the temperatures were within the correct range. No controlled drugs were kept on the premises.

Repeat prescribing processes which were appropriate and in line with guidance were in place at the practice, and GPs were aware of them. Prescription pads were kept securely and records were kept of the number of pads used and their serial numbers. Medication reviews, including those for patients with long term conditions were undertaken on a regular basis, and GPs detailed appropriate checks that they would take when prescribing medications which might either have serious side effects, or might be contraindicated with other medications.

The practice had appropriate patient group directions (PGDs) in place. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. However, some of the directions had not been reviewed within the two year period required, having last been amended in 2011.

Cleanliness and infection control

The practice had effective systems in place to reduce the risk of the spread of infection. The practice's phlebotomist was the designated infection control lead. Staff had received the appropriate infection control training, and good infection control management was observed when there was a blood spillage in the practice. Staff had access to appropriate infection control equipment including gloves, hand washing gel and spill kits both in clinical and non-clinical areas of the practice.

The practice had a thorough cleaning schedule in place which was split into various areas of the practice premises. The waiting room (including furniture), reception area, clinical rooms and patient toilet were all observed to be well maintained and clean. Hand washing sinks with elbow taps were available in all clinical rooms. A risk assessment had been undertaken in relation to the legionella bacteria.

Equipment in clinical rooms such as examination couches, scales and blood pressure monitors were also noted to be clean, and disposable rolls of paper were in place on the

couches to minimise the risk of cross infection. Infection control audits were completed on a regular basis, the last one having been undertaken in the previous two months. These were thorough with any action points clearly recorded.

Appropriate clinical waste disposal bins and sharps disposal systems were available in all of the consulting and treatment rooms. Clinical waste was collected by an external company and consignment notes were available to demonstrate this.

Equipment

There were appropriate measures in place at the practice to ensure that equipment was suitable for use. The practice had a contract with an external contractor to ensure that all equipment in the practice was calibrated and serviced yearly. We were shown that equipment was last calibrated in September 2014. This also included portable appliance testing (PAT). The equipment in the practice looked to have been well maintained.

Staffing and recruitment

Appropriate staffing and recruitment processes were followed by the practice. Recruitment in the practice was undertaken by the parent organisation, Malling Health. The policy included appropriate checks such as proof of identity and address and references. The records for these checks were centralised at Malling Health, and as such copies of photographic identification for staff was not kept at the practice. A dedicated human resources team was in place at Malling Health and was available to support staff at the practice. All administrative staff appointed within the last two years had been checked through the DBS service. Those who had been employed at the practice for some time completed a self-certified risk assessment. Some of these staff acted as chaperones in the practice, but were not left alone with patients.

Staffing levels in the practice appeared appropriate for the list size and members of staff reported that workloads were manageable and that they were well supported in their roles. Procedures and policies were in place to manage both planned and unexpected staff absence. Where the practice had to close early because of a member of staff being taken ill, the incident had been reviewed and policies had been changed to prevent re-occurrence.

Monitoring safety and responding to risk

Are services safe?

The practice had appropriate systems in place for monitoring safety and responding to risk. A wide range of risk assessments had been undertaken to ensure the safety of both staff and patients who use the service. These included assessments for Control of Substances Hazardous to Health (COSHH), fire and contagious diseases. When asked, staff were aware of the policies and they had undertaken training in these areas where appropriate. Fire alarms were tested on a weekly basis, which was observed during the inspection. The reception desk was open to the waiting room, but could only be accessed via a locked door which was not accessible from the waiting room. The practice had a policy that two members of staff should be on site at all times.

Arrangements to deal with emergencies and major incidents

A business continuity plan was in place which detailed that if there was disruption to the computer system or the building, then there were contingency steps that the practice could take. The practice had reciprocal

arrangements with a nearby practice to ensure that patient care could be provided conveniently in event that the practice was inaccessible. A fire risk assessment had been undertaken in the past two years, and the practice had fire extinguishers in place throughout the practice, all of which had been serviced within the last year.

Appropriate systems were in place to manage on site medical emergencies. All clinical and non-clinical staff with one exception had undertaken basic life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Emergency medicines were available in secure clinical areas of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, hypoglycaemia and suspected bacterial meningitis. Processes were 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.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical leads were in place for the management of specific long term conditions, and responsibility was split between both GPs and nurses in the practice.

Relevant meetings were in place at the practice including a fortnightly clinical meeting. Updates relating to clinical guidelines was a standing agenda item for clinical meetings, and both NICE and local guidelines were discussed. Meeting minutes showed a clear pathway of how changes had been integrated into the practice, including how patients with long term conditions were moved from existing treatments to new first line choices, for example where patients had been moved from Cerazette to Nacrez. Clinical staff demonstrated how they accessed NICE guidelines and examples of where NICE guidelines had been used to change practice policies were evident in staff meeting minutes. Where relevant minutes showed where information had been cascaded to reception and administrative staff. The practice also demonstrated that relevant guidance updates had been shared by way of e-mail and the practices shared drives.

The practice had made efforts to review its housebound patients to ensure that all would receive a home visit within three months. At the time of the inspection, half of these patients had been visited. During these visits, the patients had been provided with a named GP at the practice, a full review, and where required a care plan had been drawn up for them.

In general terms the practice showed favourable outcomes which were comparable to both local and national levels. All of the patients on the diabetes register had been reviewed within the previous twelve months. Eighty two percent of patients with diabetes, on the practice's register, whose last reading for IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months (a measure of diabetes management) compared to a national average of 78%. However, The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was lower than the national average (64% as opposed to 86% nationally).

Management, monitoring and improving outcomes for people

The practice had systems in place to manage and monitor care, and to provide improved outcome for patients.

The practice had completed a number of audits, including one for the management of reviews for patients taking lithium following a serious untoward incident. A number of the audits had completed an on-going two audit cycle. An audit of patients who had been taking lithium showed that some information had not been shared between the practice and other healthcare professionals providing care. The audit had highlighted several areas which needed to be reviewed and as a consequence policies in the practice had been updated, and patient medications had been reviewed. Both the lead GP and practice manager had only been appointed to the practice within the past six months, and they indicated that a fuller and more regular process of audit was in the process of being implemented. The quality outcome framework score for the last year was 87%, and at the time of the inspection an audit plan had not been instigated to improve this.

There was evidence from review of records that patients with dementia and those with mental health disorders received suitable care with an annual review of their health and care plan. One hundred per cent of patients on the practice list who had been diagnosed with dementia had received a face-to-face review in the preceding 12 months, against a national average of 83.83%.

Medicines and repeat prescriptions were issued and reviewed in line with NICE and other national guidelines. In the records reviewed of patients with diabetes and hypertension it was evident that patients had been followed up appropriately and that blood tests had been requested for a review of efficacy or where a change in medication was being considered.

Effective staffing

All new staff at the practice were provided with an induction, and on reviewing the induction policies there was an appropriate amount of both corporate and role specific induction. The practice had appropriate mandatory training in place and had a spread sheet in place to ensure that all mandatory training was completed by all staff. A review of staff files showed that certificates were retained. The practice manager who had recently joined had been mentored by an experienced practice manager from one of Malling Health's other surgeries while she familiarised herself with her new role.

Are services effective?

(for example, treatment is effective)

All of the staff who had been at the practice for more than six months had an appraisal completed in the last year, a copy of which was kept on their file. GPs at the practice also had appraisals in place, although the lead GP who had been at the practice only for a few months had yet to receive her appraisal. GPs in the practice had either been revalidated or had a date for revalidation set. (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)

Staff reported that they were supported in receiving adequate training. They also stated that they were aware of care pathways and it was clear that the responsibility of providing care for patients was shared by the whole practice team. Policies were in place that showed nurses and doctors in the practice shared the care of patients with long term conditions, and there was an adequate skill mix. For example the practice nurse had received regular updates in cervical cytology and immunisations, for which she was the practice lead. The regular clinical meeting allowed for individual cases to be discussed where required. Examples of this were in the minutes of the meetings.

Working with colleagues and other services

Appropriate systems were in place in the practice to ensure that referrals to secondary care providers and results received were managed in an efficient way. Given that all of the doctors at the practice were part time, they showed us an on-call system so that results could be reviewed promptly and any adverse findings could be managed swiftly. There was evidence that results and discharge letters were being managed in line with guidance, and these were reviewed by a GP within 24 hours.

The practice met on a monthly basis with the clinical commissioning group (CCG) for the Kingston area where issues relating to the provision of GP care in the area, and any issues arising from hospital or other secondary care were discussed. Working relationships with hospital providers in the area appeared well developed.

The practice had monthly (and sometimes twice monthly) multi-disciplinary team meetings where other professionals were invited including health visitors, counsellors, palliative care professionals, representatives of

the mental health team and district nurses to ensure people with complex illnesses, long term conditions, housebound and vulnerable patients received co-ordinated care. The practice reported that representatives did not always attend, but they tried to ensure that they did where possible. Meeting minutes were reviewed where individual patient care was discussed, as well as any learning points from complaints and/or untoward incidents. On the basis of records reviewed, the management of in and out going correspondence with all parties was appropriate, and all correspondence was managed promptly.

Information sharing

A number of regular meetings were held in the practice, including fortnightly clinical meetings, and monthly meetings for administrative staff. There were also monthly meetings for all staff at the practice. All of these meetings had clear agendas, with relevant discussion points and were minuted with action plans where required. The practice was actively involved in work with peers, other healthcare providers and the local Clinical Commissioning Group (CCG).

The electronic patient record in the practice was appropriate, although the practice manager stated that it was soon to be upgraded to a new system. Systems were in place for sharing information with the out of hours provider.

Consent to care and treatment

One of the GPs in the practice (the lead GP) had attended training on the Mental Capacity Act (MCA). The lead GP had disseminated this information to the other members of the clinical team who demonstrated applied knowledge of both the MCA and the Children's Acts of 1989 and 2004. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Staff told us that consent was recorded within the patient record and if there were any issues with consent they were discussed with a carer or parent.

Health promotion and prevention

Patients attending the practice were provided with adequate health promotion information. Posters and information leaflets were available in the waiting area

Are services effective?

(for example, treatment is effective)

detailing a number of health promotion services including smoking cessation. Details of the smoking cessation clinic were also advertised on the practice's website. The website detailed clinic times, and a wide range of health promotion advice was available, although this was not clearly signposted from the site's home page. There was also a wide range of healthcare information about a wide array of medical conditions, but again it was not clearly signposted from the home page.

The smoking cessation service had received referrals of 94% of patients in the practice who were listed as smokers. The exact uptake was unclear from the clinical records, but there had been eight people who had successfully stopped smoking in the previous year following attendance at the smoking cessation service. The practice had also provided advice in relation to alcohol consumption to 97% of patients where alcohol intake was higher than recommended levels.

The rate of uptake for cervical smear test was 79.9%, almost exactly the average for both the area and nationally. However, in other areas there were improvements that could be made, in particular in terms of health promotion.

Most notably the uptake of influenza vaccinations for those aged over 65 (of who there are a high proportion at the practice) was only 65% as compared to a 73% national average, and for those at risk aged 6 months to 64 years old the uptake was 40% as compared to 53% for the national average.

Uptake for childhood immunisations was in line with national averages. For example the uptake of immunisation for children up to 12 months was 93%, exactly in line with national averages. Uptake for the measles, mumps and rubella (MMR) vaccination at 24 months was 83% as compared to a national average of 89%, and at aged 5 years dose two of MMR was 90 % compared to a national average of 85%.

The practice had systems in place to support patients over the age of 75 who had their own named GP. GPs in the practice reported that they would proactively check health issues with older or more vulnerable patients. The practice had also begun visiting housebound patients to provide them with a care plan and to provide health promotion advice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The 2014 national GP patient survey results (latest results published in January 2015) showed that 33% of respondents said they usually got to see or speak with their preferred GP compared to the national average of 57%. Seventy per cent of patients reported that GPs gave them enough time in the consultation compared to a national average of 85% and 77% said that nurses allowed enough time as opposed to a national average of 80%. Overall 49% of respondents said that they felt that the practice was good, compared to a national average of 67%. We found that the practice had responded to patient feedback and they had introduced an action plan following the most recent practice survey in January 2015. These action points were appropriate and showed learning from feedback.

The feedback from the eight patients that we spoke to during the inspection clarified some of the scores from the patient survey. We spoke to eight patients on the day of the visit. The majority of patients explained that the practice was better than it used to be and they had noticed improvements in the past 12 months. The remaining patients interviewed did not raise any concerns in this area and reported that they had been treated positively. Evidence showed that patients felt that the practice was currently performing at a better level than it had previously.

The practice telephones were located and managed at the reception desk. The reception desk had limited room for private conversations. However, practice staff told us they could speak to patients away from the reception desk to ensure privacy if required. The reception desk was adequately contained within a joint waiting area. Notices advertising chaperoning services were prominent throughout the practice, both in the waiting area and all of the consulting and treatment rooms. Staff we spoke with were aware of the need to be respectful of patients' rights to privacy and dignity.

During the visit we witnessed staff attending to an older patient who required urgent attention. Both reception and clinical staff were respectful and compassionate to the patient, and were observed to make efforts to respect the dignity of the patient.

We observed staff interactions with patients in the waiting area and at the reception desk and noted that staff ensured

patients' respect and dignity at all times. In the consulting rooms we noted that disposable curtains were provided so that patients' privacy and dignity was maintained during examinations. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

Staff told us that translation services were available for patients who did not speak English as a first language. We were also told that a number of staff in the practice spoke languages other than English, but that there was rarely requirement for it as most patients spoke English.

The national GP patient survey from January 2015 showed that 77% of patients said that the last nurse they saw or spoke to was good at explaining tests and treatments, compared to a national average of 76%. Sixty eight per cent of patients said that the last GP they saw or spoke to was good at explaining tests and treatments, compared to a national average of 82%. Sixty four per cent of patients said the last GP they saw or spoke to was good at involving them in decisions about their care, compared to a national average of 66%. Fifty four per cent of patients said the last nurse they saw or spoke to was good at involving them in decisions about their care, compared to a national average of 74%.

Patients who we spoke to at the practice reported that services had improved since the patients survey had been completed

Patient/carer support to cope emotionally with care and treatment

One of the patients interviewed during the visit commented that as a parent she felt well supported by the clinical and non-clinical staff at the practice where treatment of her child was concerned.

When we spoke to practice staff they demonstrated an understanding of the potential social and emotional impacts of treatments and conditions. A number of the practice staff demonstrated this effectively when dealing with a patient who needed urgent medical attention during the inspection.

Are services caring?

There were leaflets in the practice relating to bereavement counselling, but patients were not signposted to bereavement services via the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of its patients and had systems in place to ensure that the level of service provided was of a high quality. The practice understood that the key population groups in the area were older patients and those of working age. The practice had arranged extended opening hours so those who were commuting could access services at more convenient hours. The practice manager stated that because the practice staff and premises was shared with the walk in service, the practice could accommodate its patients until 8pm where necessary.

The practice held information about those who needed extra care and resources, including those who were housebound, people with dementia and other vulnerable patients. This information was utilised in the care and services being offered to patients with long term needs. The assistant practice manager showed us that house bound patients were being proactively visited, and that this opportunity was being used to actively offer health services.

All patients in the practice over the age of 75 were provided with a named GP. Although none of the GPs at the practice were full time, there was a cover system in place, and information could be shared as necessary.

The practice website provided information for patients including the services available at the practice, health alerts and latest news. The list of staff at the practice was out of date as it showed five GPs at the practice where there were actually three. Information leaflets and posters about local services, as well as how to make a complaint, were available in the waiting area. Notices about how and when a chaperone might be requested were prominently displayed in consulting rooms.

The practice was in the process of starting a patient participation group (PPG) at the time of the inspection, and requests for interest from patients were prominent in both the waiting area and in the practice leaflet. The practice manager reported that efforts had been made to start a PPG a year ago, but that had not succeeded at the time due to a lack of interest from patients. When discussing the new group with the practice manager and assistant practice

manager, they reported that they wanted the group to be in place so that the practice could learn from patients and develop. Patients were able to make comments anonymously at the practice.

Tackling inequity and promoting equality

The practice had made suitable arrangements for tackling inequality and promoting equality. The practice manager reported that few patients required translation services, but appropriate systems were in place in the event that it was required. Staff told us they could use telephone and online resources in order to facilitate interpretation.

The building and all parts of the practice were accessible to wheelchair users. The patient toilets had been designed to ensure they met the needs of less mobile patients. The desks in the reception area were of an appropriate height for wheelchair users.

The practice manager stated that longer appointments could be offered, both for patients with multiple health issues and to assist any patients with learning disabilities.

Staff told us that there was a traveller community near the practice and the practice made particular effort to ensure that patients could be registered, and they made sufficient allowance to the fact that some patients did not have proof of address. There was an open policy for treating patients equally, so there were no restrictions in registration.

Access to the service

Although the premises had limited space, there was clear, obstacle free access to all patient areas. The entrance to the building had automated opening doors. Doorways and hallways were wide enough to accommodate wheelchairs of all sizes. The practice was open from 8am - 6:30pm three days per week with extended opening hours until 7:30pm in the evening twice a week. However, we were told that because the walk in clinic was operated by the same organisation and staff, patients could have access to their normal GPs until 8pm every weekday evening. Appointments were available throughout the day, including six telephone consultations per day for those patients who were unable to attend the practice.

Patients stated that they had difficulty contacting the practice by telephone, however priority was given to the need for improved customer service rather than actions to

Are services responsive to people's needs?

(for example, to feedback?)

improve the system for patients. Sixty two per cent of patients in the survey of January 2015 reported that receptionists were helpful as compared to a national average of 87%.

The practice website contained relevant information about the practice including opening times. It also contained a wide variety of information leaflets about health promotion and specific conditions, but these were not easy to locate. The practice page on participation appeared generic to the corporate provider, Malling Health, and did not specifically mention that a patient participation group (PPG) was being set up for the practice. Online repeat prescriptions and appointments were not currently offered but we were told this was in the process of being introduced.

Three of the patients that we spoke to said that appointments were sometimes difficult to obtain; five patients reported no specific concerns with the appointment system. However, all of them had noted an improvement in recent months. They did note that appointments were generally available at a time that suited them.

Staff told us that for urgent needs patients could be seen by a doctor on the same day. They told us that all babies, children and young people, the elderly and vulnerable were given priority and were seen the same day by a GP.

Information about the practice and out of hours contacts was available via the answer phone, although this information was absent from practice's website.

Listening and learning from concerns and complaints

The practice had effective arrangements in place for managing complaints and feedback provided by patients. The practice manager was the dedicated complaints lead, and suitable processes and protocols were in place. All staff were aware of the complaints process.

The practice provided details of how complaints had been managed, and they provided details of how the practice implemented changes as a result of complaints. Reception staff had been provided with customer service training following patient feedback. Complaints were reviewed regularly and an annual report was provided.

We reviewed a sample of eight complaints in the period June 2014 to March 2015 and found that actions were taken and learning implemented following the complaints. This helped ensure improvements in the delivery of care. We saw that there was a culture where the practice apologised to patients in their responses. One example we saw was here a complaint had been raised by a patient who had had their medication changed without their consent/a medication review. The practice had put a memo system in place to ensure clearer communication channels between clinical and reception staff.

Are services well-led?

Good 

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

Our findings

Vision and strategy

A vision and strategy document was in place at the practice. Members of staff that we spoke with demonstrated a general awareness of the practice's purpose. However, the responsibility for leading the practice strategically was less clear. In speaking to senior members of staff from the managing organisation, Malling Health, a corporate overview of the vision was provided but this was not specific to the practice. Neither the managerial staff from the practice nor those from Malling Health were able to specify exactly who had responsibility for leading the strategic direction for the practice.

Governance arrangements

Appropriate policies and protocols were in place, many of which were developed from template policies for Malling Health. All policies were available to staff on shared drives and hard copies were kept in the practice manager's office. Human resources policies were appropriate and the practice benefitted from a human resources team within Malling Health. The management structure for day to day queries was effective and clear.

A number of regular meetings were held at the practice including fortnightly clinical meetings and monthly meetings for administrative staff and all staff meetings. Agendas and meetings for the meetings were clear and action plans were clearly detailed and discussed at following meetings.

The working relationship that existed between the practice and the walk in centre had the potential to detrimentally impact on governance in the practice. Both services were being run by a single team, from the same premises. While this provided patients with a number of benefits (such as access to their own GP outside of normal hours) there were also drawbacks. Malling Health had not taken action to ensure that patients at Gray's Medical Centre were still provided with the highest level of care even when the walk in centre was busy. In particular, the practice had not sufficiently risk assessed the impact of the delivery of each of the services on the other. The impact of this lack of clarity on staff was clearly evident, as two members of staff

reported that the relationship between the two practices could be confusing. Staff (including the practice manager) reported that practice patients could be moved to slots reserved for patients at the walk in centre.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. QOF had been discussed at team meetings, but a strategy had not been developed from the QOF results to specifically identify which areas required improvement. A number of clinical audits had been completed, although they appeared more reactive than proactive and were not linked to a specific audit plan.

The practice had completed a recent practice survey (January 2015) and they had actively taken action to improve services in those areas where scores were notably lower than would be expected. On the basis of the small cross section of patients who we spoke to it appeared that patients had noted improvements to the service as a consequence. The practice offered patients the facility to make comments or suggestions anonymously within the practice.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us a range of risk assessments that had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

Management lines in the practice were clear, and roles and responsibilities for senior staff were outlined in job descriptions. There was a leadership structure for day to day management which had named members of staff in lead roles. For example there were leads in place for safeguarding and complaints. Information was being cascaded from Malling Health to specific staff in management roles within the practice, although lines of communication between the organisation and more junior staff members were less clear.

We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported and knew who to go to in the practice with any concerns. We saw from minutes that

Are services well-led?

Good 

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

team meetings were held regularly. 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.

The practice was closely aligned to the walk in service being offered at the same premises. This service was also run by the same staff group, had the same policies and procedures and the same contact number was provided to patients for both services. Staff told us that they found the close links and shared access could sometimes be confusing.

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

The practice responded appropriately to its patients when they provided feedback through either complaints or patient surveys. The practice demonstrated that it had made changes to its systems following patient feedback and that feedback was welcomed.

The practice was in the process of setting up the Patient Participation Group (PPG) at the time of the inspection visit.

Management lead through learning and improvement

The practice had systems and processes to ensure all clinical and senior staff learnt from incidents and significant events, patient feedback and complaints and, errors to ensure improvement. The practice had completed individual reviews of significant events and other incidents and shared with clinical and senior staff via meetings to ensure the practice improved outcomes for patients.

Staff were supported in their professional and personal development. We saw evidence of completed courses relevant to staff members' roles, and other courses that were planned to be completed. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available to all staff.

The practice was engaged with the Kingston Clinical Commissioning Group (CCG). We found the practice open to sharing and learning and engaged openly in multi-disciplinary team meetings. A practice representative (normally the Lead GP, but the practice manager in her absence) attended a monthly meeting with the CCG where various issues relating to the provision of services were discussed.