Monteagle Surgery

Quality Report

Monteagle Surgery
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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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Monteagle Surgery on 28 October 2014. The practice is rated as good overall.

Monteagle Surgery is located in Yateley in Hampshire. The service had approximately 6000 patients at the time of the inspection. The practice moved to its present site in 1989 and is in an eco friendly building. The local population serviced by the practice has a higher than national average of young people and those of working age.

The practice is a training environment and the registered manager had been a GP trainer since 2007.

We found the practice was good for providing safe, effective, caring, responsive and well-led services. Also all the population groups are rated as good.

Our key findings were as follows:

- Data showed patient outcomes are at or above the average for the locality.
- Patients said they are treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice has good facilities and is well equipped to treat patients and meet their needs.
- The practice had a clear vision and strategy and staff were clear about the vision and their responsibilities in relation to this. The practice ethos is that of a learning environment and is patient centred.
- All staff have received training to enhance their skills and enable then to provide the best possible care.
- Extended opening hours until 8pm are in place to help those patients that could not attend due to work commitments.
- Same day appointments are available when required.
- There is evidence of good integrated working with other services.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

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 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. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was learning from complaints with staff and other stakeholders.

Summary of findings

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. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular 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 virtual patient participation group 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 people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services which are supported by staff that are trained to provide advice and support, for example, staff had received training in dementia awareness.

The practice was accessible for patients with mobility problems and all services were provided on the ground floor. A hearing loop was available for patients with hearing difficulties. Home visits were offered to patients who have difficulty getting to the practice. Same day appointments and double appointments were also available. Flu clinics were held in the practice and community nurses provided flu vaccinations to patients in their own homes and warden controlled flats. There was a higher than national uptake of the flu vaccinations.

The practice had a complete register of patients requiring palliative care and held regular multidisciplinary case review meetings for these patients (at least three monthly and sooner when required). There were links to local voluntary services including a service which provided a voluntary taxi service to the patients.

There was a dedicated notice board in the waiting area detailing support for older people for example, Yately social club details, Neighbourhood Care Organisation Message in a bottle scheme (this is a national scheme which ensures that information is available to emergency services should it be required) and Podiatry Clinic. All patients in this group received an annual medication review with a named GP.

There were quarterly meetings with palliative care nurses in multi-disciplinary team meetings as part of the Gold Standards Framework. Alerts were sent to the out of hours service with regards to palliative care patients treatment and wishes.

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 and had received appropriate training. Patients were provided with help and support to promote self-management where appropriate. The specialist clinics included diabetes asthma, COPD and Learning Disability. Nationally recognised protocols are used and encourage self-management.

Summary of findings

Flu vaccinations were offered for all patients with long term conditions.

Longer appointments and home visits were available when needed.

All patients with a long term condition had a named GP and a structured annual review to check that their health and medication needs were being met. Letters for invitation to clinics and blood tests was sent to the patients followed by a reminder text. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

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, for example, there was a safeguarding register and attached escalation procedures which had last been used six weeks prior to the inspection.

There were multidisciplinary team meetings with school nurses and health visitors and good communication between these professionals. Gillick competency guidelines were in place and staff had received training and understood the sensitivity required when dealing with young people in confidence.

Links were established with the local Community Mental Health Team Youth Counselling service and patients could be referred when required and could be seen in house to reduce stigma. Appointments were available for children to be seen outside school hours.

Immunisation rates were higher than the national average for all standard childhood immunisations.

Midwives and GPs shared the care of pregnant women and screening is carried out for diabetes and mental health issues. Pregnant women with mental health problems are seen in joint clinics with the midwife and community mental health services.

The practice had the second highest uptake of chlamydia screening in the clinical commissioning group area and offered opportunistic screening.

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

Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care for example by offering extended hours to allow working patients to be seen.

An annual health check was offered to all patients aged forty years and over with health promotion and lifestyle advice.

Opportunistic smoking cessation advice and blood pressure checks were offered to patients. The practice website offered health promotion & lifestyle advice. Travel clinics were available and appointments for these could be accessed on line. A flu clinic was held on a Saturday to allow working people to attend.

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 including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and those with dementia and the attendance was above the national average. It offered longer appointments for people with a learning disability.

We were told that the traveling community were welcome to walk into the practice and would be seen. There is a mobile home site locally where travelling families live and when patients present from this site they are offered screening and immunisations.

A carers register was in place in order to identify carers who needed further support. Translation services were available to the practice as required.

Safeguarding training had been carried out and staff were aware of their responsibilities and how to access help. Staff had completed equality and diversity training.

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). There was a process in place for rapid response for people experiencing poor mental health to ensure they were seen within a four hour period. All patients had been offered or received an annual physical health check and regular blood testing had taken place for patients on specific medications. For patients that did not attend they were telephoned or visited.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health,

Summary of findings

including those with dementia. These teams included community mental health team, eating disorder team and early intervention in psychosis team. The local consultant psychiatrist and keyworker attend the quarterly multidisciplinary team meetings. Alerts are in the patient notes for three monthly blood tests.

Staff had attended dementia training. Sign posting information was available in the reception area. Staff had received training in the Mental Capacity Act.

Summary of findings

What people who use the service say

Patients using the practice had completed 37 CQC comment cards. All of the cards contained positive feedback however three also mentioned difficulties in getting an appointment. Patients stated that they were listened to, treated with dignity and respect, consistently provided with excellent care and they also stated that they felt the staff were helpful, friendly, courteous, respectful, kind and professional. The patient responses also noted that the surgery was clean and tidy. A recent patient survey reported that the practice was above the national average score for patient satisfaction with making appointments and being seen by their chosen GP. The practice has a virtual patient participation group with 80 members covering the population groups that communicate via email and are able to provide feedback to the practice.

Monteagle Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and they were accompanied by a GP specialist inspector.

Background to Monteagle Surgery

Monteagle Surgery is located in Yateley in Hampshire. The service had approximately 6000 patients at the time of the inspection. The practice moved to its present site in 1989 and is in an eco friendly building. The local population serviced by the surgery has a higher than national average of young people and those of working age. At the time of the inspection there was one GP partner and two salaried GPs one of which was on maternity leave and being covered by a GP known to the local population. There was a vacancy for a salaried GP and the practice was advertising this post. The practice was supported by three practice nurses, a practice manager and six receptionists. The practice is a training environment and the Registered Manager had been a GP trainer since 2007.

Access to the practice was good for those with impaired mobility and patients were seen in ground floor consulting rooms. The practice had applied for a grant to assist with updating the premises and the work would include new sinks and flooring and the provision of a new treatment room.

The Quality and Outcome Framework (QOF) is a method used to measure the quality of the services provided in general practice. Monteagle Surgery QOF report indicated higher than national average scores.

The out of hours service is provided by a separate service accessed via the national 111 service. Patients are instructed to ring 111 out of hours and if required they will be referred onto the local out of hours service to be provided with advice or a consultation.

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.

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included information from NHS England, the local CCG and Healthwatch. We looked at the 2014 patient survey and corresponding action plan the practice had in place. We carried out an announced inspection on 28 October 2014. During our visit we spoke with staff (GPs, a nurse, managers and administrative staff). We observed how patients were being cared for and reviewed personal care or treatment records of patients. We reviewed thirty seven comment cards where patients and members of the public shared their views and experiences of the service to get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

Detailed findings

- 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)

Good

Are services safe?

Our findings

Safe track record

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Clinical meetings are held weekly with all staff including locum GPs and trainee GPs and incidents, national patient alerts, patient feedback, complaints, Clinical Commissioning Group feedback and health and safety issues were discussed and actions monitored.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that 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.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated at the weekly meeting and via email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the weekly practice meeting 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 people and adults.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, there was a safeguarding register and attached escalation procedures which had last been used six weeks prior to the inspection. Notes were summarised by a practice nurse (clinically trained) and they highlighted any new patients with safeguarding concerns. A recent accident and emergency attendance audit yielded no cases with safeguarding concerns. We looked at training records which showed that all staff had received relevant role specific training on safeguarding and a training plan was in place to update training annually. Clinicians had received level three safeguarding training and all other staff had completed level two. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

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

There was a chaperone policy in place and this service was advertised in the practice, in the practice handbook and on line. Staff who acted as chaperones were trained and had criminal records check via the Disclosing and Barring Service. Staff were aware of their responsibilities and how to access help. Staff had completed equality and diversity training. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

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 and this was recorded daily when the practice was open and seen to be within the correct ranges.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked anonymised patient records which confirmed that the procedure was being followed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Every clinical room had a numbered box with prescriptions and medical certificates, which were returned to the locked office at the end of the day.

GPs did not routinely carry medicines in the bags used for home visits but would assess the need take any medicine required from practice stock when visiting patients.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. We saw evidence that all relevant staff had completed infection control training and that infection control was part of the induction training and annual updates were planned. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed within the timescales on the action plan.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. A spillage kit was easily accessible in the reception area.

Notices about hand hygiene techniques were displayed in relevant areas. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory employment in previous jobs and qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Staff roles were risk assessed to ensure that all staff dealing with patients received a DBS check. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice is currently recruiting a salaried GP.

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 keep patients 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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health

Good

Are services safe?

and well-being or medical emergencies. For example, there were emergency processes in place for identifying acutely ill children and young people and posters about acutely ill children were displayed in all consulting rooms.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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, the implications for the practice's performance and patients 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 and the practice nurses supported this work, which allowed the practice to focus on specific conditions. GPs were encouraged to pursue outside interests, one GP was the Clinical Commissioning Group's(CCG) prescribing lead and another had special interests in Ear Nose and Throat treatment and dermatology. One salaried GP worked in local Sexual Health service and another was the respiratory lead for the CCG.

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 continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes held weekly confirmed that this happened.

Nursing staff had lead roles in chronic disease management and had received appropriate training. Patients were provided with help and support to promote self-management where appropriate. The specialist clinics included a diabetes clinic that is held specifically for those who find it difficult to manage their condition Flu vaccinations were offered for all patients with long term conditions. Longer appointments and home visits were available when needed. All patients with a long term condition had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

An annual health check is offered to all patients aged 40 years and over.

All patients with a long term condition had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

A carers register was in place in order to identify carers who needed further support.

Translation services were available to the practice as required.

There was a process in place for rapid response for people experiencing poor mental health to ensure they were seen within a four hour period. All patients had been offered or received an annual physical health check and regular blood testing had taken place for patients on specific medications. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken in the last year. The audits completed demonstrated the changes resulting since the initial audit.

- Audit undertaken for Diabetic control in under 55's
- Accident and Emergency attendance audit to identify safeguarding concerns.
- Lithium audit to identify whether blood tests were being undertaken

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the Quality Outcomes Framework and performance against national screening programmes to monitor outcomes for patients. This practice was scoring above the national average.

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 best treatment for each patient's needs.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It 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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs, who were being encouraged to also have outside interests, for example in dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either have 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. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example dementia training, employment law and dealing with complaints. 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.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and paediatric phlebotomy. Those with extended roles for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or people with poor mental health. These meetings were attended by district nurses, social workers, palliative care nurses, community mental health teams and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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 and to alert the out of hours provider of any complex care needs.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called EMIS (which they had recently migrated to) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child age 16 years or younger has the maturity to make their own decisions and to understand the implications of those decisions). A GP gave an example of a young woman who asked for a termination of pregnancy. The GP was able to talk to the patient and encouraged her with the GPs support to speak to her parents who then were very supportive.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to young people and the practice was the second highest in the CCG for providing these tests.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

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 all patients with a learning disability and they were offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months.

The practice's performance for cervical smear uptake was above the national average, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services which are supported by staff that are trained to provide advice and support, for example, staff had received training in dementia awareness.

The surgery was accessible for patients with mobility problems and all services were provided on the ground floor. A hearing loop was available for patients with hearing difficulties. Home visits were offered to patients who have difficulty getting to the practice. Same day appointments and double appointments were also available. Flu clinics were held in the surgery and community nurses provided flu vaccinations to patients in their own homes. There was a higher than national uptake of the flu vaccinations.

The practice had a complete register of patients requiring palliative care and held regular multidisciplinary case review meetings for these patients (at least three monthly and sooner when required). There were links to local

Good

Are services effective?

(for example, treatment is effective)

voluntary services including Yately Care which provided a voluntary taxi service to the patients. All patients in this group received an annual medication review with a named GP.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated higher than the national average for patients who rated the practice as good or very good. The practice was also above the national average for its satisfaction scores on consultations with doctors and nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 37 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, respectful, friendly, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

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 the practice respondents said the GP involved them in care decisions and felt the GP was good at explaining treatment and results. Both these results were above the national standard expected.

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

Patient/carer support to cope emotionally with care and treatment

The patients who completed the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen 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 were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Patients told us that if families had suffered bereavement, their usual GP contacted them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient'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.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had process in place to deal with these. For example the opportunistic offering of immunisations to travelling families.

The practice had access to translation services.

The practice provided equality and diversity training to all staff. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patients with disabilities for example a hearing loop was in place. Services for patients were situated on the ground floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

There was a register of patients who are at risk, for example, children whose circumstances make them vulnerable, palliative care patients and patients with a learning disability.

Access to the service

Appointments were available from 8am until 6.30 pm on weekdays with extend hours until 8pm one night per week to accommodate those patients that could not be seen during normal working hours. Flu clinics had been held on Saturdays.

Comprehensive information was available to patients about appointments on the practice website and in the practice information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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, the patients were directed to an out of hours provider.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that all patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

- Older people and people with long-term conditions – home visits are available where needed and longer appointments when needed. Where a patient wants to attend the practice there are links to a local voluntary taxi service to assist with this.
- Families, children and young people – Appointments are available outside of school hours for children and young people, the premises are suitable for children and young people and there is a counselling service for young people on site.
- Working age people – There is an understanding of the needs of the working age population and services reflect this by providing extended opening hours.
- People whose circumstances may make them vulnerable – There is evidence of partnership working to understand the needs of the most vulnerable in the practice population, longer appointments for those that need them, flexible services and appointments.
- People experiencing poor mental health - mental health needs of the practice population including within hard to reach groups is monitored and informs service provision, longer appointments for those that need them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 in the practice information leaflet.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Complaints were discussed at the weekly staff meeting and staff members have completed training in dealing with complaints.

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 were part of the practice's strategy and business plan. The practice ethos was patient centred.

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 six of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All six policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. Members of staff we spoke to were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns and enjoyed working at the practice.

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. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice is currently a high achiever and regularly achieves QOF scores above the national average.

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 an audit took place to assess the numbers of patients referred for MRI scans who had presented with a history of headaches. As a result of this audit a protocol is now in place.

The practice had arrangements for identifying, recording and managing risks.

Leadership, openness and transparency

We saw from minutes that team meetings were held weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, in relation to recruitment and whistleblowing which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had an active virtual patient participation group (PPG) which has steadily increased in size to 80 members at the time of the inspection. The PPG included representatives from various population groups; including older people, people with poor mental health and working age people.

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

Management lead through learning and improvement

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

The practice was a GP training practice.

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