Churchill 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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Churchill Medical Centre on 2 June 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services to the six population groups we inspect - People whose circumstances may make them vulnerable, Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); and People experiencing poor mental health (including dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- Staff were aware of the practice's vision and values and contributed towards them. The practice had achieved an Investors in People award.
- The practice proactively sought feedback from staff and patients, which it acted on. This included creating a specific children's waiting area.
- The practice has a schedule of audits, which included re-auditing.
- Patients appreciated the flexibility of being able to access services at any one of three sites.
- Parentcraft classes were provided and the cost covered by the practice.

Summary of findings

- The practice had some satisfactory Quality Outcome Framework (QOF) outcomes but was below the national average in a number of areas including diabetes and dementia.
- Patient satisfaction with the appointment system and the availability of their preferred GP fell below the Commissioning Contracting Group (CCG) and national averages.
- We found some out of date oxygen masks, although the practice did also have masks that were within their expiry date.

We saw several areas of outstanding practice including:

- The practice had won a NICE (National Institute for Health and Care Excellence) shared learning award in 2014 for its antibiotic prescribing programme which was adopted by the CCG.
- The health care assistants ran a 'Weigh to go' exercise and healthy eating class in the evenings and leaflets advertising this were on display in the waiting room.

However there were areas of practice where the provider needs to make improvements. Importantly the provider should:

- Ensure all equipment, including oxygen masks are within their use by date.
- Provide health care assistants with identified clinical supervision.
- Ensure all clinical staff have up to date hepatitis B vaccination.
- Ensure established protocols regarding immunisations are in place, particularly regarding patient specific directions.
- Introduce a cleaning checklist so staff know what has been cleaned and when.
- Ensure that fire emergency action plans are regularly rehearsed, and the fire risk assessment periodically reviewed.

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.

The premises were clean and patients commented they had no concerns regarding infection control. Medicines were managed well and there were appropriate procedures and equipment in place to deal with medical emergencies. Staff recruitment was thorough.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' 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. A number of GPs had undergone additional training in, for example, diabetes, child health and mental health.

Data showed patient outcomes varied. Some were above the average for the locality but some fell below the CCG and/or national average, most notably for flu vaccinations and the expected identification of the prevalence of asthma. The practice had a schedule of audits and could evidence how patients benefitted from the actions taken as a result.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice above the CCG and national average for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Information for patients about the services available was easy to understand and accessible albeit it was provided in very small print. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Patients spoke highly of the care they had received following a bereavement.

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 CCG to secure improvements to services where these were identified. Patients said urgent appointments were usually available the same day but that it was not easy to always get an appointment with a named GP. Patients appreciated having the option of an appointment at either the main surgery or one of the two branch surgeries.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

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 patient reference group (PRG) was active. Staff had received inductions, regular performance reviews and attended meetings and events. They felt the practice had a 'no blame 'culture and they worked together as one team. Staff said the practice supported them to maintain their clinical professional development through training and mentoring.

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. There were 676 patients in this category registered with the practice, representing 3.9% of the practice population. All of these patients had a named GP. The practice had below the CCG average for the number of patients in all age groups above 65 years.

The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. In conjunction with a national charity the practice had developed and piloted an award winning Stay Well at Home programme, which targeted the vulnerable elderly for extra support to enable them to remain independent in their home.

The practice nurses undertook routine reviews of all our housebound patients. For housebound patients experiencing an acute problem requiring immediate attention, the practice made use of the rapid response team who saw patients within 2 hours (the rapid response team is a pilot initiative between London Ambulance Service and Kingston CCG. It was created to offer an alternative service to an ambulance dispatch and can see and treat people in their own homes).

Data showed that the practice performed in line with the CCG average for most conditions commonly found in older people, however it fell below the CCG average for the percentage of patients aged 65 and older who have received a seasonal flu vaccination, achieving 62.35% compared to 73.24%. Post the inspection the practice commented that this had now risen to 69%.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions (LTC). The practice had a below average number of patients with a long-standing health condition, with 35.5% compared to 54.0% nationally. There were 3,256 patients in this category registered with the practice, representing 18.8% of the total practice population.

Nursing staff had lead roles in LTC care including providing a diabetic clinic (up to tier 3), asthma, chronic obstructive pulmonary

Summary of findings

disease (COPD) and coronary heart disease (CHD) management. The health care assistants had been trained in a number of areas to assist with LTC management, including smoking cessation and weight management.

All these patients had a named GP and a structured annual review to check that their health. Longer appointments and home visits were available when needed. 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.

We saw that over 90% of patients with COPD, CHD and diabetes had had a review in the past year however QOF outcomes for patients with diabetes were below the national average, whilst the percentage of patients aged over 6 months to under 65 years in the defined influenza clinical risk groups that received the seasonal influenza vaccination was 45.66% compared to 52.29% nationally.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were 4,201 patients in this category registered with the practice, representing 24.3% of the total practice population. The practice had above the national average for the number of children registered who were aged under four years. Appointments were available outside of school hours and the premises were suitable for children and babies. In 2014, in response to requests from parents, the practice created a children's waiting area.

The level of childhood immunisations were in most instances comparable to the CCG average. Exceptions to this were Meningitis C at 12 months (67.7% compared to the CCG average of 74.8%) and PCV booster at 5 years (79.3% compared to the CCG average of 87.4%).

We saw good examples of joint working with midwives and health visitors. A health visiting team was based at the practice and offered a drop in baby clinic as well as providing ante and post natal services. A midwife from the local hospital visited the practice bi-weekly to provide ante-natal care.

The practice offered all patients access to parent-craft classes free of charge. These included early pregnancy classes and breastfeeding support. The practice offers a walk-in family planning clinic for registered and unregistered patients, and one of the nurses was also able to offer coil and implant fitting.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). There were 12,584 patients in this category registered with the practice, representing 72.9% of the total practice population, which was above the national average. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was proactive in offering online services, such as repeat prescriptions, as well as a full range of health promotion and screening that reflected the needs for this age group, for example by offering a meningitis C vaccination programme for college students. There were extended opening hours from 8.00am to 8.00pm weekdays as well as Saturday mornings. The practice also offered telephone consultations for those unable to get into the surgery

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. There were 2,827 patients in this category registered with the practice, representing 16.4% of the total practice population. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice worked with a local interpreting service to facilitate appointments for patients who did not have English as a first language.

Nurses arranged routine visits to patients who were housebound and and/or very old.

A domestic violence worker was available at the practice once a week if any patient wished to speak with them.

Summary of findings

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 were 616 patients in this category registered with the practice, representing 3.6% of the total practice population.

The practice exceeded the England and CCG averages for having a comprehensive care plan in place for patients with schizophrenia, bipolar affective disorder and other psychoses achieving 91% compared to the England average of 86% and the CCG average of 97.7%. However it fell below the national average for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months – achieving 60.27% compared to 88.65% (and the CCG average of 91.4%). It also fell below the national average for patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months, achieving 71% compared to the national average of 84%. The practice had taken steps to address this. For example it had rewritten its dementia protocol and had increased the number of cognitive assessments being carried out.

One of the GPs was completing a diploma in mental health run by the CCG.

Summary of findings

What people who use the service say

The National Patient Survey 2014 indicated patients rated the practice above the CCG and national average for being involved by the GP in decisions about their care and for the GP explaining care and treatment. It was also above the CCG and national average for the nurse involving patients in their care and explaining care and treatment. However it fell below the CCG and national averages in, for example, the ease of getting through on the phone, and for the ease and experience of getting an appointment.

Patients we spoke with on the day of the inspection, and feedback from the CQC comment cards, supported these findings.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all equipment, including oxygen masks are within their use by date.
- Provide health care assistants with identified clinical supervision.
- Ensure all clinical staff have up to date hepatitis B vaccination.
- Ensure established protocols regarding immunisations are in place, particularly regarding patient specific directions.
- Introduce a cleaning checklist so staff know what has been cleaned and when.
- Ensure that fire emergency action plans are regularly rehearsed, and the fire risk assessment periodically reviewed.

Churchill Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP, practice manager, practice nurse and expert by experience. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Churchill Medical Centre

Churchill Medical Centre is situated in Kingston upon Thames, Surrey, one of 27 practices within Kingston CCG. The practice had a Personal Medical Services (PMS) contract for providing general practice services to the local population. It also provides some enhanced services such as extended hours and remote care monitoring.

Churchill Medical Practice is registered with the Care Quality Commission to carry on the regulated activities of Family planning; Diagnostic and screening procedures; Surgical procedures; Maternity and midwifery services and Treatment of disease, disorder or injury. The surgery opening hours are Monday to Friday 8:00am - 8:00pm and Saturday 8:30am - 11:10am (the telephone lines closed at 10:00am on Saturdays and at 6.30pm during the week).

The practice had a patient list of approximately 17000 at the time of our inspection. The staff team at the practice were nine male GPs, eight female GPs, five female practice nurses, three female healthcare assistants and a practice administrative team including a practice manager, an operations manager, manager for IT, reception and the office, and over 20 reception and administrative staff.

The practice had above the England average of patients aged up to four; for patients aged between 25-29, 30-34, 35-39 and 40-44 but below the England average for all age groups above 50 and those aged between 10 and 19.

The practice has a lower percentage (than the national average) of people with a long standing health condition (35.5% compared to 54.0%); and a lower percentage (than the national average) of people with health related problems in daily life (37.1% compared to 48.8%). The average male and female life expectancy for the practice was slightly above that of the national average.

The main BME groups in the borough are Indian/British Indian (4%), Sri Lankan (2.5%), African (2.3%) and Korean (2.2%). The Korean population in New Malden is estimated to be the largest in Europe. The Indices of Deprivation rank Kingston upon Thames as the third least deprived local authority in London. The practice has a deprivation score of 13.8, compared to the national average of 23.6, however the rate of homelessness applications accepted in Kingston for 2013-14 was 3.04 households per 1,000 (which was higher than the England average of 2.32).

Churchill Medical Centre has two additional branch practices situated in Surbiton and Ham, Surrey. They were visited as part of this inspection. The practice has opted out of providing out-of-hours services to its own patients, directing them to the NHS 111 service.

We noted that the practice maintained a record of significant events however it had not notified the Care Quality Commission, where appropriate, of these, in accordance with the Care Quality Commission (Registration) Regulations 2009. This was brought to the attention of the provider.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.This provider had not been inspected before and that was why we included them.

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 that we hold about the practice, such as policies and procedures, audits, complaints and significant event logs; and asked other organisations such as the CCG, Healthwatch and local residential home to share what they knew. We carried out an announced visit on 2 June 2015. During our visit we spoke with a range of staff including doctors, nurses, administrators, and receptionists, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. For example staff discovered that some test results were being sent to the inbox of a registrar who had left the practice, and were therefore not being reviewed. As a result all test results were now sent to a central inbox to be allocated. A buddy system was also introduced so that each test result would be sent to an alternative GP when staff were on leave or off sick.

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

One of the partner GPs led on significant events. Staff completed an in-house form and these were reviewed by the lead GP and the information disseminated as necessary in, for example, managers meetings, clinical meetings, non-clinical staff meetings and as part of staffs' continuous professional development (CPD). Where appropriate they were also shared with colleagues in the CCG. The practice treated all clinical incidents as significant events and logged them accordingly. Information relating to the events was stored on a specific drive as were the minutes of staff meetings so staff not present could easily see what had been discussed. The CPD meetings were not minuted.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the significant event log from April 2014 to the present date. There had been 14 events. Staff recorded in the log the date, whether the event was clinical or administrative, whether it had caused or had had the potential to cause harm, a summary of the event and the learning from it. The practice had conducted an analysis of these 14 events, of which six related to clinical issues, and deduced there was a common theme which related to the need to recognise the importance of information sharing between primary and secondary care. Any serious adverse events that had compromised patient safety had been reported via an NHS England patient safety incident report to the National Reporting and Learning System (NRLS). These should also have been reported to the Care Quality Commission. Annually the practice reviewed its significant event log to assess if identified actions had been carried out.

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. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared, for example it was discovered that Pertussis(whooping cough) vaccination invitations were not being given to all pregnant patients. The practice took action and set up an automatic process on the electronic patient record system so that letters would be printed once it had been added to the system that a pregnant patient had had a GP consultation. In addition, safetynet searches were run weekly to catch any that may have been missed. Where patients had been affected by something that had gone wrong with any aspect of their care they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were reviewed by the practice manager and/or the deputy practice manager. If they related to a clinical issue they were disseminated by email to the clinical staff. Other alerts were disseminated if appropriate to all practice staff. Staff we spoke with were able to show us examples of recent alerts, including one regarding Hydroxizine (a medicine which is used in dermatitis, urticaria and anxiety).

Reliable safety systems and processes including safeguarding

The practice had safeguarding policies and procedures in place to protect vulnerable patients. The policies gave information and guidance to staff to look out for possible signs of abuse, neglect or harm. All staff had received training in adult and child protection in the last three years and dates for refreshing training were noted in each of the staff files we inspected. Records showed both clinical staff and non-clinical staff had received the appropriate level of child protection training for their role. GPs had completed Level 3 child protection training; nurses Level 2 and all

other staff Level 1. The local adult safeguarding team had recently given practice staff training in referrals, protocols and processes. Staff we spoke to were able to tell us what they would do if they suspected abuse and they knew where the relevant contact details were for the local safeguarding team. One GP had told us they also had the number saved in their phone.

The practice had a safeguarding lead who was one of the GP partners. Staff told us they would report any safeguarding concerns to the lead and take direction as appropriate from them. Staff were able to give us an example of where they had acted when they had concerns over an adult who was in a vulnerable home situation; and also provided minutes of a child protection case conference which the lead GP had attended.

There was a system to highlight vulnerable patients on the practice's electronic records. An alert 'hook' automatically led staff to the separate, specific drive where relevant safeguarding information was stored . Staff could access relevant policies and procedures, minutes of safeguarding meetings and other pertinent information in this designated drive on the practice's computer system. There was a single point of access telephone number for the local safeguarding team, displayed in each of the consulting rooms, and staff felt they had a productive relationship with that team. The practice's safeguarding lead, and one of their GP colleagues who had a specific interest in child health, met monthly with the local health visitors.

There was a chaperone policy, and patients were advised on the television screen in the waiting room that a chaperone could be requested (this facility was not available at one of the branch surgeries, neither was information displayed to inform patients about the chaperone policy). (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). Three health care assistants and two receptionists had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Patient records were stored in a secure manner. There was an access to records policy in place as well as policies relating to information governance and information security.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Vaccines kept at the branch surgeries were appropriately refrigerated. The practice nurse had the designated responsibility for checking the temperature each day. If they were not present then the receptionist had been given appropriate guidance and clearly told us that they would check the temperature and phone it through to the main surgery each day. We confirmed this with staff at the main practice.

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

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, the numbers logged and they were kept securely at all times. Patients could request repeat prescriptions in person, in writing or online. The practice had an identified clerk who oversaw repeat prescriptions. Prescriptions were processed by the clerk and passed to the GPs for signature. The usual turnaround time was 48 hours. If a patient was due a medication review a reminder was added to their repeat prescription. We were told prescription requests for high risk medicines were scrutinised to ensure they were appropriate. The practice had not carried out any audits of the prescribing system. We were told that there had not been any prescribing errors that had required reporting.

The practice's performance for antibiotic prescribing was comparable to the CCG average (0.2% compared to 0.38%).

Good

Are services safe?

Their prescribing for some anti inflammatory medicines was better than the CCG average. For example the number of Ibuprofen and Naproxen Items prescribed as a percentage of all Non-Steroidal Anti-Inflammatory drug (NSAID) items prescribed was 85.4% compared to 71.25% nationally (data suggests that these two NSAID's have fewer side effects than other NSAID's).

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw up to date sets of PGDs. The health care assistants administered vaccines and other medicines using a coding system rather than the expected Patient Specific Directions (PSDs). We were told that the practice was in the process of changing to PSDs. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD. We saw from staff files that two of the HCA's had undergone immunisation training within the last three years and refresher dates had been set.

The practice did not hold stocks of schedule two or three controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

We observed the main practice and both branches to be clean and tidy, with the exception of one dirty carpet in one of the treatment rooms. This had been highlighted by the practice in its own infection control audit and we were told the carpet would be replaced when funds permitted it. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice used an external company to clean the premises. A schedule of the areas to be cleaned each day was provided, however there was no daily record maintained of what had actually been cleaned. This was queried with the cleaning company who felt that a daily record signed by their cleaner was unnecessary as everything on the schedule was cleaned daily.

An infection control policy and supporting procedures, such as a sharps policy and how to handle specimens, were available for staff to refer to. Personal protective equipment including disposable gloves, aprons and spillage kits were available for staff to use and staff were able to describe, for example, how they would test and dispose of a urine sample.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence that the lead had carried out an audit in September 2014. This had highlighted a number of areas where action was required. We saw some of these actions had been completed, others were underway. Staff were aware of the audit and the actions arising from it. The audit cycle had not yet been completed with a re-audit.

We requested confirmation that clinical staff had up to date vaccination against Hepatitis B however the practice was unaware of the status for the majority of its doctors.

Consulting rooms were fitted with disposable curtains which were changed every 18 months. Single use equipment was used where possible to help reduce the risk of infection.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The last legionella test was completed on 21 May 2015.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They said that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was in place. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was May 2015. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The most recent calibration had taken place in October 2014.

The main practice and both of the branch surgeries provided a 'grab' bag for GPs to take on home visits. We

checked the content of these bags at the branch surgeries and found they contained calibrated (or brand new) blood pressure machines and the emergency medicines in them were within date.

Staffing and recruitment

The practice had a recruitment policy, last reviewed in February 2015, which ensured a consistent process was followed when staff were employed permanently or temporarily. We reviewed 10 staff records and saw information was recorded for professional registration checks, photographic identification, references and where staff had worked previously and full employment histories. Staff had criminal record checks undertaken using the Disclosure and Barring Service (DBS). Where some non-clinical staff had not had DBS checks this was assessed as low risk because these members of staff did not work directly with patients.

New staff completed an induction prior to starting work. We saw checklists on file indicating that staff had been advised about medical emergency equipment, awareness of dangerous equipment and fire safety procedures. Staff we spoke to confirmed they had received an induction prior to starting their role and were satisfied with the information they received. One person we spoke to who had been recruited recently told us they received a full induction that involved reading the practices policies and procedures, training on the computer system and shadowing other members of the team.

The practice had a policy for staffing that ensured the right skill mix of staff were employed at all times. The minimum staffing requirements during normal circumstances on each day included four GP's, one practice nurse, three receptionists, one secretary and two managers. We saw this was fulfilled on the day of our inspection. During the evenings the staff reduced to one GP, one practice nurse and one receptionist.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. We were told the practice offered in total 69 GP appointments (in person or by phone) per 1000 patients. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the operations manager was the identified health and safety representative.

A health and safety audit had been carried out in May 2015. Identified risks were highlighted along with the action that needed to be taken. In addition, each area of the practice had a specific risk assessment record. We reviewed the ones for the baby clinic area; the health visitor room; one of the consulting rooms and one of the exits to the building. Each assessment contained an identification of any hazards, who might be at risk, whether the risk was controlled and what, if any further action was required.

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

We visited both branch surgeries as part of this inspection. Each had appropriate emergency medical equipment in place, including oxygen and a defibrillator however we found out of date oxygen masks in both locations, although there were also some that were within date. All the emergency medicines at the branch practices were in date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of telephones, and loss of utilities. The plan also included details of the minimum staffing levels required to operate. The practice was buddied with another surgery in the CCG area so additional resources, if necessary, where available. The plan had last been reviewed in March 2015.

Good

Are services safe?

An external company had carried out a fire risk assessment in November 2013. Staff carried out monthly fire alarm checks however fire drills were not practiced regularly, the last one having been some three years previously.

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. Guidelines were discussed with other practices at the monthly Council of Members (members included one GP from each practice in the area).

We discussed with GPs how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff by email. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The GPs told us they led in specialist clinical areas such as diabetes, child health and mental health and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice had developed an antibiotic prescribing programme aimed at reducing such prescribing for self limiting conditions (an illness which will either resolve on its own or which has no long-term harmful effect on a person's health). The programme had been adopted by the CCG and every practice provided with posters, literature and patient leaflets. This initiative had earned the practice a NICE Shared Learning Award in 2014.

The practice had signed up to several enhanced services including minor surgery, remote care monitoring, extended hours and Rotavirus and Shingles Immunisation (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice's medical secretaries dealt with referrals – they typed the dictated referral letters and sent them to the local Kingston clinical assessment service that assesses referrals and initiates the choose and book option using strict referral criteria. If referrals were rejected , the assessment service informed the practice of this via email. Referrals that fell within the two week wait deadline were emailed and a delivery receipt requested (patients have the right to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected). This was added to the patients notes. Staff had a checklist to follow when dealing with referrals and this was on display in the office.

The practice used computerised tools to identify patients who, for example, were at high risk of admission to hospital or had long term conditions. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We were told the senior partners monitored the practice's referral rate as this was seen as a training issue.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. Same gender GP consultations, chaperones and language line for non-English speakers were all provided. Patients with a learning disability or mental health needs were offered annual health checks.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients.

The practice showed us a summary of audits they had carried out since April 2014. These included an audit of Aminophylline monitoring and prescribing; an audit of deaths to see whether any were preventable and whether cancer deaths of patients of the practice had been diagnosed in A&E; and an audit of patients on long term PPI (proton pump inhibitors) and diuretics/digoxin who should have their magnesium levels monitored. Of the nine audits conducted during this period five had been re-audited or had a date for re-audit. The Aminophylline audit showed that only 56% of relevant patients had had their theophylline levels checked within the last 6-12

months and that 46% were prescribed generic as opposed to the preferred branded aminophylline. This audit was scheduled for re-audit in January 2016. The initial audit of patients on long term PPI had found that there were 102 patients who were prescribed either a thiazide diuretic, a loop diuretic or on digoxin, and were also prescribed a PPI. Of these only 4% had had a magnesium level recorded. Changes were implemented within the practice, with the aim of raising this to 80%. Three re-audits had subsequently been carried out. The first showed 2.8% had been tested in the interim period. This improved to 55% and 57% following the additional re-audits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice achieved 87.9% of total available points (790 out of 900) compared to the national average of 94.2% for the year 2014. For clinical outcomes it achieved

85.3% (which equates to 520.08 out of 610 points: 9.4% points below the CCG and 7% below the England average). It achieved above the CCG and England averages for QOF points relating to, for example, atrial fibrillation, osteoporosis and palliative care. However it achieved below the CCG and England averages for some outcomes, including mental health (70%), dementia (82%), diabetes (82%) and stroke and transient ischaemic attack (73%). This practice was an outlier for flu vaccinations for over 65 year olds, and also for the ratio of expected against reported prevalence of asthma.

As an example, the percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification 1-4 within the preceding 12 months was 81.62% compared to the national average of 88.38%. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 72.47% compared to 81.61% nationally.

The practice exceeded the England and CCG averages for having a comprehensive care plan in place for patients with schizophrenia, bipolar affective disorder and other psychoses achieving 91% compared to the England average of 86% and the CCG average of 97.7%. However it fell below the national average for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months, achieving 60.27% compared to 88.65% (and the CCG average of 91.4%). It also fell below the national average for patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months, achieving 71% compared to the national average of 84%. The practice was aware of all the areas where performance was not in line with national or CCG figures and discussed with us their plans to address this. For example the practice had rewritten its dementia protocol and had increased the number of cognitive assessments being carried out. The practice provided us with QOF figures for the first quarter of 2015 which indicated, for example, that the practice performance in relation to asthma prevalence, dementia and diabetes had improved. Doctors also commented that some data had been lost when the practice switched to the new patient record system, which had had an effect on QOF points; and there has also been some issues regarding coding of patient diagnoses which again the practice felt had had an impact on the outcome figures.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff, with the exception of the health care assistants who informed us they did not receive formal clinical supervision. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which followed national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by a GP. They also checked all routine health checks were completed for long-term conditions such as diabetes, and patients with diabetes were provided with an insulin 'passport' where appropriate. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We checked five records of patients with diabetes. We saw that the notes were clearly written, that care plans were in place and that care plans and medicines were reviewed at least annually.

Good

Are services effective?

(for example, treatment is effective)

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had a training policy in place that was followed and managed by the practice manager. The policy included the list of mandatory training requirements which were; Fire Safety, Equality, Diversity and Human Rights, Health Safety and Welfare, Safeguarding Children and Adults, Infection, Prevention and Control, Moving and Handling, Information Governance, Basic Life Support and Conflict Resolution. Staff spoke positively about the training and personal development they received. We saw evidence of training received by staff in all the mandatory areas that were listed in the policy.

The practice manager confirmed there was a system in place to monitor staff's training. They showed us a traffic light system which flagged up an alert when refresher training was required for each member of staff. This was to ensure all staff were receiving up to date development and training to support their role. Training records were kept in an organised system on the computer and certificates were filed in individual personal development files. We reviewed the training records and found them to be well organised with training and refresher dates noted in each file. Clinical staff had completed the continued professional development requirements that were necessary to maintain their professional registration. We saw this was well organised by the practice manager in the filing systems.

New staff were provided with appropriate inductions, including copies of key polices and procedures such as those relating to safeguarding, infection control and basic life support. We noted a good skill mix among the doctors. Two of the GPs carried out minor surgery; one had a diploma in dermatology whilst others had additional training in acupuncture, diabetes, child health and mental health. There was also a good skill mix amongst the nurses, with specialists in, for example, diabetes, asthma, COPD and contraceptive implants.

Other staff were encouraged to upskill, and there were opportunities for them to embark on new career paths, for example moving from reception work to becoming a health care assistant.

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. The practice provided us with a spreadsheet of dates for all GPs. (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 the staff we spoke to confirmed they had received annual appraisals and their personal development had been met through the training opportunities. Staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the health care assistants had been enrolled on the care standards certificate course. They spoke positively about their development and told us there were no issues with the practice allowing them time to train and develop alongside their roles.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example one of the practice nurses had been trained to fit coils and implants and talked us through the protocol, including gaining consent.

Senior staff shared responsibility for managing poor performance. If there were clinical concerns with a GP then they would be dealt with by one of partners. If issues related to something like timekeeping then it would be dealt with by the practice manager.

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 these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on

Good

Are services effective?

(for example, treatment is effective)

the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt, including scanning a copy of the correspondence into the patient's record. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice provided a GP service to a local nursing/ residential care home. Feedback from the home was positive. They were satisfied with the weekly GP surgery provided at the home; appreciated having a named GP and felt that the repeat prescription service worked well.

The practice told us they had a lower number of patients attending A&E or emergency admissions than the CCG average. Our data supported this as it showed the practice was below the national average with 9.86% compared to 13.6%.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs, for example those with end of life care needs; or to discuss issues such as safeguarding. These meetings were attended by, for example, district nurses, social workers, palliative care nurses and paediatricians. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. Incoming information was allocated to the appropriate GP or nurse. Urgent communication was passed to the duty GP. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. For example, 'Do not resuscitate' forms were passed to the out of hours provider and a copy was held in the Summary Care record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

The practice told us that they used a generic code when referring a patient using the two week wait criteria. This then enabled staff to easily search for that code each month to ensure that no referrals had been missed.

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.

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). The practice had 27 patients with a learning disability. Over 90% had had an annual review by the time of our inspection.

The clinical staff we spoke with demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. GPs told us they would make sure they had understood by asking the patient to repeat the procedure back to them.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

The practice did not routinely offer a health check to all new patients registering however there was a culture among the GPs to use their contact with patients to help

Good

Are services effective?

(for example, treatment is effective)

maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. Whether or not a patient smoked was recorded at the initial registration. In the preceding 15 months the practice had recorded a smoking status for 9283 patients, of whom 1054 had stated they smoked. Between January – March 2015, 77 patients had attended a smoking cessation appointment. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. These were carried out by the HCAs and they referred the patient to a nurse or GP if concerns were identified. The practice had recorded the BMI for 3084 patients within the last 18 months and had identified 592 patients who were obese. The practice was currently determining what additional support could be offered to these patients.

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 immunisations was mixed, with some results similar to or above average for the CCG and some below. For example 90% of children aged 24 months had received a meningitis C booster vaccination compared to the CCG average of 87.6%; and 95.2% of 12 month old children had received the Dtap/IPV Booster compared to the CCG average of 93.3%. However the practice fell below the CCG average for Meningitis C vaccination at 12 months (67.7% compared to the CCG average of 74.8%) and 79.3% for the PCV booster at 5 years old, compared to 87.4% for the CCG.

The practice was an outlier for flu vaccinations and for asthma prevalence. It fell below the CCG average for seasonal flu vaccinations for patients aged over 65 (62.35% compared to 73.24%) and for patients aged over 6 months to under 65 years in the defined influenza clinical risk groups achieving 45.66% compared to the CCG average of 52.29%. The practice had taken steps to address this by holding more flu clinics; improving advertising of clinics; starting clinics a little earlier in the year and both writing and telephoning patients to invite them to attend. Patients requiring travel vaccines could access a range of information on the practice website, including a specific form to complete if an appointment was required.

The practice's performance for cervical smear uptake was71.35%, which was lower than the CCG average of 77.52%. This was acknowledged by the practice and they accepted that they needed to do more to follow-up with patients who did not attend,not only for cervical screening but also for vaccinations. The practice encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. For example, if a patient had made an appointment to see a GP or nurse on an unrelated matter, staff would opportunistically encourage those who were eligible to attend screening.

Regular evening Parentcraft Classes were delivered at the practice by trained practitioners. These were open to patients not registered at the medical centre as a community facility. The cost was covered by the practice and we were told the classes were so popular that they had three times the local average of births amounting to around 300 new patients a year. Two of the nurses and all the doctors were trained in contraceptive care and could be seen for consultation during general appointment times. The practice also ran a specialist nurse-led family planning clinic each Tuesday between 16:30 and 19:30. The practice had a minor surgery clinic, and also had a drop in child clinic run by health visitors every Wednesday afternoon.

The health care assistants ran a 'Weigh to go' exercise and healthy eating class in the evenings and leaflets advertising this were on display in the waiting room.

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 2014, and a survey sent to over 200 patients (with a 30% response rate) undertaken by the practice. We also spoke to patients, reviewed completed CQC comment cards and met with members of the patient reference group.

The evidence from all these sources showed patients were generally 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 proportion of respondents who described the overall experience of the GP surgery as fairly good or very good was 81.5%, compared to a national average of 85.2%, and a little below the CCG average of 83.3%.Just under 81% of patients who responded said that the last time they saw or spoke to a nurse, the nurse was good or very good at listening, which was slightly higher than the national average of 79.1%, and the CCG average of 77.3%. The practice achieved a similar result (86.8%) to the CCG (85.7%) and national average of 87.2% for how well the GP listened.

Satisfaction with the time given by the nurse was comparable to both the CCG and national average (79.7% compared to 78.2% and 80.2% respectively), whilst satisfaction with the time given by the GP (86.5%) was similar to the national average of 85.3% and exceeded the CCG average of 82.4%. The practice's surveys indicated that year on year, patient satisfaction had risen.

The practice's own, most recent survey, carried out in 2014 in conjunction with the patient reference group (a patient reference group (PRG) is a group of patients registered with a practice who work with the practice to improve services and the quality of care) showed that the practice had, for the first time in its surveys, achieved positive ratings for all its GP services of above 70%. For the nurses' services, all of the criteria had improved, with two of the ratings at 88% and all other scores above 90%.

Patients we spoke with were appreciative of the flexibility the branch surgeries offered, and told us they preferred to use the branches as they were quieter and calmer; and getting an appointment was often easier.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and the vast majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, attentive, approachable, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive and both related to the (short) length of the appointment time, so they had to chose which problem to discuss. We also spoke with eight patients on the day of our inspection. All told us they were very 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.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with their line manager who would investigate these and any learning identified would be shared with staff.

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 2015 showed 76% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. Both these results were above the CCG (71% and 79%) and national averages (74% and 82%). The practice achieved similar results, above both the CCG and national averages, for how well the nurse explained treatment and involved patients in their care. The results from the practice's own satisfaction survey showed that year on year patient satisfaction had increased.

Good

Are services caring?

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and most felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language and staff demonstrated a good understanding of the demographics of their patient population.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example 83% of those patients who commented on the last time they saw or spoke to a GP, said the GP was good or very good at treating them with care and concern. This was slightly higher than the CCG average (79.9%), and the national average of 82.7%. Seventy seven percent said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 74% and national average of 78%.

The patients we spoke with on the day of our inspection were positive about the emotional support provided by the practice. For example, they highlighted that staff responded compassionately when they needed help and provided support when required.Following a bereavement two patients told us the practice called them every day for two weeks to check on their wellbeing.

The practice had a protocol in place to reduce possible stress on bereaved patients. If a patient died, staff would ensure the notes were reviewed and all relevant people informed so as to reduce the likelihood of correspondence being sent to the deceased.

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.

We saw that the practice engaged regularly with the CCG and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example one of the practice GPs sat on the CCG board and one of the partners had regular contact with the CCG to discuss governance issues. Two of the practice management team were lead service managers for a 'Winter Pressures' Service that had been commissioned by Kingston CCG. One of the practice partners was on the steering group board and the surgery premises at Churchill Kingston was also used as one of the four host sites.

The practice had piloted a scheme offering clinics in deprived local areas. Although the scheme ran for three years it was ultimately ended as the uptake was very low. Saturday morning health checks were offered to patients as part of a CCG initiative. The practice was currently in discussion with Public Health England to identify ways to address alcohol dependency and early intervention in patients with mental ill health.

Whilst it was not always possible for a patient to see the same GP, we saw from patient records that the GPs themselves may book a subsequent consultation to ensure continuity. We also saw good communication between the GPs regarding patients. Home visit requests were triaged by the nurses and a rota was in place for the GPs so they shared this workload.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Patient Reference Group (PRG). For example it had posted information on its website to show which GPs were working at any given time and at which of the three locations.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, those who required a translator; those with mental ill health and mothers for ante and post natal check ups. Patients with diabetes who were being reviewed were given 40 minute appointment slots. The practice population was predominantly but not exclusively English speaking. Staff had access to online and telephone translation services if they were needed.

The practice was designed to allow easy wheelchair access to all surgeries and treatment rooms. An accessible toilet was provided. We noted however, that at times it was difficult for wheelchair users to access the practice due to visitors to the practice parking partially across the footpath.

In response to requests from patients, the practice had created a specific children's waiting area. This had been attractively painted and provided toys, a changing area and baby weighing scales.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice considered equality and diversity training to be mandatory and we saw from staff records that this training had been provided.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments online. The website stated the surgery opening hours were Monday to Friday 8:00am - 8:00pm and Saturday 8:30am - 11:10am (the telephone lines closed at 10am on Saturdays and at 6.30pm during the week). Appointments were available during these times. Telephone consultations were also available. Appointments could be booked up to two weeks in advance, including on Saturdays. Appointments for the nurse, midwife, and the asthma and diabetes clinics were also bookable in advance. Patients could telephone either the main practice or either of the branches to get an appointment at any one of the three locations. There was a self check-in system at the main practice (but not at the branch surgeries). Patients were advised that if they were

Good

Are services responsive to people's needs?

(for example, to feedback?)

more than five minutes late for an appointment they would have to rebook. Patients could request to see the same GP for each consultation but were advised that this could potentially mean a wait of up to 14 days.

Outside of these times, patients were asked to telephone the normal appointment number, when they would be directed to the NHS 111 service and/or advised they could use the nearest walk in centre. The website also informed patients they could contact NHS111 for advice if out of hours. Requests for home visits were dealt with by the practice nurses, who would assess the patients condition and arrange an initial GP visit where they felt it was appropriate. Requests for an emergency appointment were triaged by the designated duty GP if there were no appointments available.

Patients could download a practice information leaflet, or collect one from the practice. This contained a considerable amount of information including surgery opening hours; a list of all staff, clinical and non-clinical; how to obtain repeat prescriptions; details of the complaints procedure; services for non-English speakers and details of the health services provided. The leaflet was produced using very small typeface which would make it difficult for people with visual impairment. Health promotion information was available in the waiting room at the main practice, for example, leaflets regarding whooping cough vaccinations. A few leaflets were available at the branch surgeries. For example there was one copy of a leaflet about a weight management programme at the practice in Ham.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to one local care home by a named GP on a specific day each week, and outside of that day to those patients who needed one.

Information from the national patients survey 2014 showed patient satisfaction with the appointment system fell below that of the CCG and nationally. For example, 49.1% responded positively to the ease of getting through on the phone, compared to 63.9% in the CCG and 71.8% nationally. Eighty two percent said they were able to get an appointment when they wanted one (CCG 83%, national 85%) whilst 87.7% were satisfied with the convenience of the appointment compared to 90.5% in the CCG and 91.8% nationally. The practice had responded to this by increasing its daily GP sessions to four; adding additional consulting rooms and extending opening hours.

Patients we spoke with had mixed views about the appointment system. Some felt it worked well, and it was easy to get through on the phone and get an appointment; others stated that it was very hard to get through and when they did invariably all the appointments had already been taken. Receptionists confirmed to us that generally most appointments for the day would have been taken by 10am. Similar mixed views were expressed with regard to the waiting time pre-appointment, with some patients not experiencing problems but others saying they always had to wait, sometimes for up to 30 minutes. Patients using the branch surgeries were more positive about the ease of getting an appointment as they found them less busy. The proportion of respondents to the GP patient survey who stated that they always or almost always saw or spoke to the GP they preferred was 24%, compared to a CCG average of 48.2% and a national average 53.5%. Just over 64% said their experience of making an appointment was good or very good (CCG 67.7%, national 73.8%) however these outcomes notwithstanding, the number of patients who rated their overall experience of the practice as good or very good was 81.5%, which was just below the CCG average of 83.3% (national average 85.2%).

Patients also commented on the attitude of reception staff and the GPs. Most feedback was positive, particularly from patients at the branch surgeries. Feedback from the national patient survey 2014 showed that patients satisfaction with reception staff was above the CCG average – 77% compared to 74%, and just below the national average of 78%.

The practice's extended opening hours during the week and on Saturdays were particularly useful to patients with work commitments however the PRG fed back that the availability of weekend appointments was not widely known. There was a similar lack of awareness regarding the availability of a chaperone.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

The practice website provided the practice's complaints procedure, and both a complaint form and a feedback form. Patients were informed their complaint would be recorded and acknowledged within three working days, with a substantive response four weeks from receipt. Patients were advised that should any matter remain unresolved they had the right to refer the matter to the Health Ombudsman. The practice leaflet, which was also available on the website, clearly set out how patients could complain and also provided the telephone number and email address of the CCG customer care officer. There was no information on display however, either at the main surgery or the branches, to advise patients that they could make a complaint and how to do so.

We were provided with the complaints log for 2014/15, and a summary of them completed by the practice. The log contained an outline of each complaint and the outcome of it. There were 27 recorded complaints in that time. We saw that each had been investigated, and where appropriate apologies made to the complainant. Nearly one quarter of the complaints related to the attitude of staff (both clinical and non-clinical); whilst a further 25% related to clinical care. The summary assessed if there were any emerging themes and also highlighted the learning that could be taken from the issues raised. From the information provided it was not possible to determine if complaints had been actioned in a timely manner as no dates were entered into the log however we reviewed a number of the complaint reports and saw that an acknowledgment was usually sent within four to five days, with a full response sent within a reasonable timescale.

The practice provided a Friends and Family Test box and forms for patients to complete however the box was on its side and not obvious to patients. The practice had a patient reference group however there was no information on the practice website to inform patients of this.

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, and told us they had a particular focus on vulnerable patients. Continuous professional development meetings were used to discuss strategy and development of the vision. The practice values had been reviewed by the GPs in 2014; and then again by all staff in 2015. We spoke with18 members of staff who understood the vision and values and felt they had been involved in developing them.

The stated practice vision and values included delivering a service that combined the personal care of the traditional family doctor with the best that modern general practice could deliver. To achieve this the practice's statement of purpose stated staff would constantly seeking new ways to serve their patients, with innovations including Parentcraft classes, extended weekend opening hours and children's clinics.

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, including those relating to child protection, adult safeguarding, consent and access to records. All of these had been reviewed annually and were up to date. Minor surgery was carried out at the practice and we saw that the deputy practice manager oversaw the protocol and ensured lab results were followed up promptly.

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 one of the partner's was the lead for safeguarding. Other staff were designated lead s for complaints and HR/personnel for example. We spoke with 18 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. They felt there was a 'no blame' culture within the practice.

In 2005 the practice received the Royal College of General Practitioners'(RCGP) Quality Practice Award, one of only 2% of practices in England to do so (the award aim to help practices improve their quality of care for patients and their carers. It is the highest award attainable from the RCGP).

One of the GP partners, who was also a trainer and an appraiser led on overall governance, and they and the practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing below national standards in some areas. We saw that the data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits, over and above those required by QOF, which it used to monitor quality and systems to identify where action should be taken. For example an audit of Aminophylline monitoring. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice identified, recorded and managed risks. It had carried out risk assessments and where risks had been identified action plans had been produced and implemented, for example the assessment of the baby clinic area had identified that some storage boxes could prove a hazard to patients and so they were moved to a more appropriate location.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed.

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

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

Leadership, openness and transparency

The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service being delivered. The practice had achieved an Investors in People award (Investors in People is a management framework for high performance through people) and also a Quality Practice Award from the Royal College of General Practitioners.

We saw from minutes that a number of meetings were regularly held. For example there were joint monthly nurse and HCA meetings; quarterly GP meetings; continuous professional development meetings every four to six weeks and monthly reception staff meetings. Minutes of meetings were shared so there was a clear understanding by all of how the practice was performing in terms of delivering high quality care in a safe environment. The practice manager belonged to a practice manager forum and attended a monthly meeting. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Team meetings were also used to ask staff for their feedback. We also noted that team away days were held bi-annually.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the PRG, surveys and complaints received. It had an active PRG, which consisted of five members. Three representatives of the group met with us and outlined their aims, which included improving communication with the practice (to, for example, ensure patients were aware of the extended hours offered), producing a regular newsletter and expanding its membership. The PRG felt that the practice was supportive, responsive, that the appointment system worked reasonably well and that it was unreasonable for patients to always expect to see the same doctor.

The practice manager showed us the analysis of the last patient survey, carried out in 2014, which was considered in conjunction with the PRG. The results and actions agreed from these surveys were available on the practice website. Action taken as a result of the survey included updating the website guidance for appointments by adding a document showing when and where the GPs were scheduled to be working Monday to Friday. The practice had carried out a demand and capacity exercise to ensure that sufficient appointments were available at the right times. The demand and capacity exercise was completed in February 2015, and as a result changes to the rota had been made to provide additional appointments at times of greatest demand. The practice has also tried Sunday opening but there had been very little take up.

Data from the national patient survey showed the proportion of respondents who described the overall experience of the GP surgery as fairly good or very good was 81.5%, compared to the CCG average of 83.3% and the national average of 85.2%. The practice also achieved slightly below the CCG (75.5%) and national (78%) averages, for the number of patients who would recommend the practice to others achieving 73.6%. The practice's own 2014 survey indicated that patient satisfaction with the service provided was rising, with the practice achieving a positive result of over 70% in all areas it reviewed.

The practice had also gathered feedback from staff through, for example, away days twice a year. It had also recently asked staff to complete the Health and Safety Executive stress at work questionnaire and they were in the process of analysing the results. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. As a result of staff feedback the practice had installed a water cooler; a computer free coffee room and a quiet staff room.

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 10 staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very

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supportive of training. Staff were encouraged to upskill, and there were opportunities for them to embark on new career paths, for example moving from reception work to becoming a health care assistant.

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. We saw minutes of continuous professional development (CPD) meetings where significant events had been discussed; and also reviewed the schedule for forthcoming CPD meetings. Planned topics for discussion included NICE updates; Vitamin D toxicity and gastroenterology.