

Greystone House Surgery

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Greystone House Surgery on 19 October 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- The practice had comprehensive business continuity plans in place in case of major incidents occurring.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP or their 'buddy' and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

An annual summary of complaints and significant events was posted on the website and noticeboards emphasising the practice's commitment to a transparent, learning culture which benefitted both patients and the practice.

However there were areas of practice where the provider should make improvements:

Summary of findings

To review the reasons for the high level of exception reporting in respect to cervical screening.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events and an annual summary of significant events and complaints was posted on the website and in the waiting room.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Good



Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for most 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.

Good



Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Alerts were added to patients' records to highlight special needs requiring longer appointments.
- When young adults turned 16 they were sent information on their rights regarding confidentiality and what the practice and other services could offer them.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example a representative of the local wellbeing service worked within the practice. The wellbeing service was a joint project between the NHS and borough and county councils whereby vulnerable individuals or families could receive advice, guidance, help and support locally to improve their health and lifestyles. The clinicians within the practice could refer patients to the service.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day via an emergency clinician system.
- 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff, patients and other stakeholders.

Good



Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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.

Good



Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Each nursing and residential homes had a named GP to enhance continuity of care. Larger homes had weekly/ fortnightly ward rounds to proactively review patients and plan care. Homes could use the practice bypass number.
- The practice worked with the home managers and Community Matrons to reduce inappropriate 999 calls or unnecessary unplanned admissions, and had set up systems to ensure patient wishes were met regarding their preferred place of death.
- Home visits occurred daily and clinicians met up and discussed housebound patients at the end of morning surgery. One of the GPs met the community matron monthly to discuss the management of patients on their caseload. Additionally the practice held quarterly multi-disciplinary team meetings.
- Patients identified at risk of unplanned admissions were offered a personalised care plan, which (with consent) was shared with the Out of Hours and ambulance services.
- All patients over 65 were notified of their named accountable GP.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Each GP had special interests and overall responsibility for a long term condition (LTC).
- Registers were held of patients with each LTC and were used to identify, recall and monitor patients with each condition.
- Self-management was promoted and a Wellbeing Advisor was based at the practice for holistic care, advice, support and sign-posting to other organisations (voluntary sector and social care).

Good



Summary of findings

- The practice worked with the local Medicines Management team who carried out audits and ensured that they prescribed effectively and appropriately.
- Other specific services included psoriasis clinics, reviews of patients with stoma products by a GP and acupuncture also carried out by one of the GPs.
- The percentage of patients with diabetes, on the register, in whom the last long term glucose level was 64 mmol/mol or less was 84% (clinical commissioning group (CCG) average 80%, national average 78%).
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice worked with a local hospice, district nurses and community matrons in managing patients approaching the end of life, following a nationally recognised framework.

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were similar or higher than the local clinical commissioning group rates, and similar to or lower than the national rates, for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding 5 years was 90% (CCG average 81%, national average 82%).
- All patients were seen on the day if requested and children were seen first if attending for triage.
- The midwives ran ante-natal clinics at the practice. Post-natal checks were carried out at six weeks.
- Doctor and practice nurse appointments were co-ordinated for baby's eight week check and first immunisations.

Good



Summary of findings

- Flu vaccines were offered to pregnant women and children. Clinics were available after school and on Saturdays. The practice had an interest in patients with gestational diabetes.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw that the practice regularly met with midwives and health visitors.
- To welcome children, together with their patient participation group (PPG), the practice held an art competition with prizes for children who entered, and continued to display the entries around the surgery.
- The practice wrote to patients who turned 16, informing them of the confidential nature of their consultations and aspects of access to make it easier for them to contact them. They also trialled after school drop-in sessions.

Working age people (including those recently retired and students)

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

- 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 including viewing records, making appointments, ordering prescriptions, and emailing. They sent texts for appointment reminders, information regarding for example flu clinics, and accepted text cancellations.
- They offered a full range of health promotion and screening that reflected the needs for this age group.
- The practice used the Electronic Prescription Service to transfer prescriptions to patients' pharmacy of choice.
- The practice offered extended surgery hours from 7.30am every weekday and on Tuesday afternoons until 8pm for patients who found it difficult to attend during regular hours. Appointments could be made for GPs, phlebotomy and new patient checks.

Good



People whose circumstances may make them vulnerable

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

Good



Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice provided care for a local home for people with learning difficulties.
- 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.
- Annual reviews were carried out at a location which the patient was most comfortable with.
- The practice used an interpreter/translator as required and had trained a member of staff in sign-language. Alerts were added to patients' records to highlight special needs requiring longer appointments.
- The practice made it as easy as possible for all women to be seen and fully register all children to ensure they had access to immunisations.
- The practice welcomed homeless patients, liaised with local support groups, and used the practice address or their mobile as a point of contact. They worked with the local alcohol & addiction multi-disciplinary team counsellor.
- The practice had a carer's lead who liaised with carers and a local carer's association. They prescribed carer breaks and actively seek out young carers. Alerts are added to highlight the potential need for flexibility. They offered annual checks for carers with a clinician and also a member of the carers association.
- They had recently organised a number of coffee mornings in conjunction with their patient group for more isolated patients.

People experiencing poor mental health (including people with dementia)

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

- 81% of patients diagnosed with dementia that had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%.

Good



Summary of findings

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record was 94% (CCG average 93%, national average 88%).
- One GP was the dementia and Mental Capacity Act lead for the practice and the practice had recently increased their prevalence figures for dementia from 58.5% to 74%.
- Staff had a good understanding of how to support patients with mental health needs and dementia. They were Dementia Awareness trained and were aware to raise concerns should a show signs of cognitive impairment.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- Patients with complex mental health needs were invited for annual physical/psychological reviews and the practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations, they could also self-refer to in-house psychological therapies or counselling.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above local and national averages. 247 survey forms were distributed and 105 were returned. This represented 1% of the practice's patient list.

- 83% of patients found it easy to get through to this practice by phone compared to the national average of 73% and clinical commissioning group (CCG) average of 75%.
- 83% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76% and clinical commissioning group (CCG) average of 79%.
- 97% of patients described the overall experience of this GP practice as good compared to the national average of 85% or clinical commissioning group average of 87%.

- 93% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79% or clinical commissioning group average of 82%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards which were all positive about the standard of care received. Care was described as excellent and very good. Staff were described as professional, helpful, courteous and caring.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The results of the Friends and Family Test showed that 296 patients out of 323 were extremely likely to recommend the surgery to friends and family (92%). Also 317 patients were likely or extremely likely (98%) to recommend the practice.

Greystone House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Greystone House Surgery

Greystone House Surgery offers personal medical services to the people of Redhill, Reigate, Merstham and Earlswood. There are approximately 13,300 registered patients.

The Greystone House Surgery is run by six partner GPs (three male and three female). The practice is also supported by four salaried GPs (all female) which include GPs with a special interest in rheumatology, family planning and palliative care. Additionally there is one nurse practitioner, three nurses and three health care assistants. The team also includes a practice manager and an office manager and 18 administrative and reception staff.

The practice currently has two GP trainees and also teaches medical students.

The practice runs a number of services for its patients including asthma and COPD clinics, child immunisation, diabetes clinics, well women clinics, smoking cessation, ECGs and 24 hour blood pressure monitoring, new patient checks and travel health clinics. The practice also carries out minor surgical procedures including vasectomy and cryotherapy on the premises.

The practice also hosts additional services for the benefit of patients from other surgeries as well as their own. This includes the district nurse team, midwives, neurology and

gynaecology services. There are also several community providers that work from the practice such as ultrasound services, wellbeing prescriber, retinopathy, bowel screening, a smoking cessation advisor and counsellors.

Services are provided from:

99 Station Road, Redhill, Surrey, RH1 1EB.

The practice has two levels; all surgeries and treatment rooms are situated on the ground floor and support services such as counsellors, consultants, midwives and ultrasound services are on the first floor. As the building is built on a slope, both floors have direct access to the ground to ease disabled access.

Opening hours are Monday to Friday 8.30am to 6.30pm. The practice is shut between 12.30pm and 1.30pm. There are extended surgery hours on Monday to Friday from 7.30am and until 8pm on Tuesday evenings. In an emergency the emergency clinician can be contacted between 8am and 8.30 am and at lunchtime by telephone. Pre-bookable appointments with GPs are available up to one week in advance.

When the surgery is closed patients can access out of hours care via the 111 telephone number.

The practice population has a slightly lower number of patients aged 65+ than the national average and an average number aged 18 years or less. There is a lower than average number of patients with a long standing health condition and slightly lower than average number of patients with a caring responsibility. The percentage of registered patients suffering deprivation (affecting both adults and children) is lower than average for England and slightly higher than for the local Clinical Commissioning Group (CCG).

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 October 2016. During our visit we:

- Spoke with a range of staff; GPs, a Nurse Practitioner, Nurses, HCAs, the practice manager and administration and reception staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- 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 were provided for specific groups of people and what good care looked 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).

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

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of all significant events. These were initially investigated by the practice manager and then, depending on the type of event the issue was discussed at a weekly clinical meeting or at a receptionist meeting (four to six weekly). Decisions and changes were recorded and disseminated to staff. If appropriate the issue would be followed up at a later date. All significant events were summarised at the end of the practice year and an anonymised annual summary of significant events and complaints was posted on the website and in the waiting room.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example it was noted that a male patient had not been recorded as living at the same address as some children. This was because of a typographical error in the recording of the address across the records. Changes were made to the registration form to staff were prompted to add all household members as a result.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. All staff were encouraged to report any suggestion of safeguarding concerns for children and vulnerable adults and guidance booklets were available in all rooms. We saw examples of safeguarding concerns raised about both children and vulnerable adults.
- A notice in the waiting advised patients that chaperones were available if required. Only nurses and health care assistants (HCAs) acted as chaperones and were trained for the role. All had received an appropriate Disclosure and Barring Service (DBS) check. (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best

Are services safe?

practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice had a comprehensive plan for servicing equipment and general maintenance.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a staffing policy and a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff covered planned and unplanned absences as required. The practice did not use locums to cover GP absences. Salaried GPs and partners were asked to cover and we saw a recent example where this had occurred

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There were also panic buttons which alerted the front desk.
- All staff received annual basic life support training and there were emergency medicines available.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had comprehensive business continuity plans in place for major incidents such as power failure, telephone failure, flu epidemics or building damage. The plans included emergency contact numbers for staff. All partners and the practice manager had copies at home. The practice had a 'buddy' surgery close by. A log was maintained of incidents that led to a disruption in business continuity and the action taken to rectify it.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results at the time of the inspection were 100% of the total number of points available. Exception reporting for the percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 20% which was higher than the CCG (6%) and national average (6%). Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014 - 2015 showed:

- Performance for diabetes related indicators were similar to the clinical commissioning group (CCG) and national average. For example the percentage of patients with diabetes, on the register, in whom the last long term blood glucose level was 64 mmol/mol or less in the preceding 12 months was 84% (CCG average 80%, national average 78%)
- Performance for mental health related indicators was similar to the CCG and national average. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94% (CCG average 93%, national average 88%)

There was evidence of quality improvement including clinical audit.

- There had been seven clinical audits completed in the last two years, three of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation and peer review.
- Findings were used by the practice to improve services. For example, recent action taken as a result included reducing the waiting time for offering appointments for vasectomy from six to eight weeks down to four to six weeks.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff (including salaried GPs) had an annual appraisal followed by a review six months later to discuss progress against their personal development plans. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. GPs openly discussed the findings of their revalidation assessments at clinical meetings. All staff had received an appraisal within the last 12 months.

Are services effective?

(for example, treatment is effective)

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Multi-disciplinary team (MDT) meetings took place with other health care professionals on a quarterly basis when care plans were routinely reviewed and updated for patients with complex needs. Meetings involved GPs, nurses, district nurses, community matrons, district nurses and specialist diabetes and Alzheimers nurses. Monthly meetings took place between the lead GP for the most at risk patients and the community matron. Palliative care meetings were also carried out three monthly with the district nurses and representatives from the local hospice.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. A template was used by all clinicians to verify mental capacity if appropriate.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent for minor surgical procedures such as vasectomy was thorough and consistent.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Well man and Well woman clinics and smoking cessation advice was available.

The practice's uptake for the cervical screening programme was 70%, which was similar to the CCG average of 74% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 91% to 96% (CCG 78% - 79%, national average 93% - 93%) and five year olds (71% to 87%) were similar to the CCG average, but lower than the national average (CCG average 69% - 86%, national average (81% - 95%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40-74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 31 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with four members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 97% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 94% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%

- 94% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 85%.
- 100% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised. Patients identified to be particularly at risk were invited to a meeting with their named GP who agreed a care plan with them and their carer.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were higher than local and national averages. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 94% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%)

The practice provided facilities to help patients be involved in decisions about their care:

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the rooms informing patients this service was available.
- The clinical system alerted staff if the patient was visually or hearing impaired.
- Patients could hand write on a card if they had something confidential that they wished to convey to staff. There was also another room that the staff could take the patient to discuss confidential matters.
- Some languages other than English were spoken by staff members (Polish, Portuguese, French and Urdu)
- The surgery had trained a member of staff in sign language.
- Hearing loops were available upstairs and downstairs.
- The practice and other local surgeries had worked with Mencap to produce 'easy read letters' and a 'passport' for patients with learning difficulties.
- Alerts were added to patients' records to highlight special needs requiring longer appointments.
- When young adults turned 16 they were sent information on their rights regarding confidentiality and what the practice and other services could offer them.

- The PPG ran monthly coffee mornings and staff encouraged patients who may benefit from contact with other patients to attend.
- To welcome children, together with their patient participation group (PPG), the practice held an art competition with prizes for children who entered, and continued to display the entries around the surgery.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 260 patients as carers (2% of the practice list) 2% of those were young carers. The practice had a carers lead and had contact with a local support agency. Carers were offered an annual health check with the health care assistant and were put in contact with local agencies by the carer lead if appropriate. Additionally written information was available to direct carers to the various avenues of support available to them. There was a 'carer's corner' in the waiting room.

Staff told us that if families had suffered bereavement, the practice sent them a sympathy card and offered support as appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Examples included local and national care plan schemes. Additionally a representative of the local wellbeing service worked within the practice. The wellbeing service was a joint project between the NHS and borough and county councils whereby vulnerable individuals or families could receive advice, guidance, help and support locally to improve their health and lifestyles. The clinicians within the practice could refer patients to the service.
- The practice offered early morning appointments from 7.30am on Monday to Friday and Tuesday evening until 8.00pm for commuters and other patients who could not attend during normal opening hours.
- There were longer appointments available if required for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- For non-urgent queries the practice could be contacted via email.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were disabled facilities on each floor, a hearing loop and translation services available. Staff had access to allow them to send easy read letters.
- There was disabled parking available.
- To promote confidentiality phones were answered upstairs until 4.30pm when staff numbers decreased and calls were taken at reception.
- The practice registered homeless patients under the practice's address.

Access to the service

Opening hours were Monday to Friday 8.30am to 6.30pm. The practice was shut between 12.30pm and 1.30pm. There

were extended surgery hours on Monday to Friday from 7.30am and until 8pm on Tuesday evenings. In an emergency the duty GP could be contacted between 8am and 8.30am and at lunchtime by telephone.

Pre-bookable appointments with GPs could be booked up to one weeks in advance. Patients requesting urgent appointments spoke to an emergency clinician (often the prescribing nurse practitioner) who would phone them back and either offer telephone advice or book them an appointment with themselves or a GP later in the day as appropriate.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages.

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 79%.
- 83% of patients said they could get through easily to the practice by phone compared to the CCG average of 75% and national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Patients requesting a home visit were rung back by the nurse practitioner to assess the suitability and urgency of the visit.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective 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.

Are services responsive to people's needs? (for example, to feedback?)

- We saw that information was available to help patients understand the complaints system. This included information on the website, on practice leaflets and on posters in the waiting room.
- All complaints including low level verbal complaints to receptionists were recorded and reviewed.

We looked at ten written complaints received in the last 12 months and found that these were satisfactorily handled, dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. A summary of complaints and significant events was posted on the website and noticeboards each year.

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 mission to deliver high quality care and in a friendly and caring environment.

- The practice had a mission statement which was displayed on the website and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with

patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us, and we saw evidence that, the practice held a variety of regular team meetings.
- Each GP had special interests and overall responsibility for a long term condition (LTC).
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted that team away days were held every 12 months.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. Notes on the website, in the waiting room and in the practice brochures encouraged patients to feedback both positive and negative experiences to the practice.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, discussed relevant practice issues with representatives of the practice and submitted proposals for improvements to the practice management team. They also produced a regular newsletter which included an update of practice news written by the practice manager. Examples of instances where the practice had acted on feedback included: The practice received

Are services well-led?

Good 

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

feedback via an audit that the waiting time for vasectomies was too long at six to eight weeks. They managed to reduce this to four to six weeks which was the best that could be attained as there had to be a 'cooling off period' prior to vasectomy. Also the GP national survey revealed that patients felt rushed during nurse appointments. This was because the nurses were trying to be efficient and fit more in to an appointment, as a result of the feedback some appointments were lengthened. The PPG also participated in fundraising for the practice and had most recently paid for the installation of an informational TV screen in the waiting room. There was a summary of anonymised patient comments in the waiting room.

- The practice had gathered feedback from staff through staff meetings, appraisals, discussions and away days. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example the practice had discussed the GP patient survey with all staff groups and as a consequence increased the number of full time GPs and introduced a GP 'buddy' system for when GPs were away. This improved continuity of care and had the operational advantage that staff knew who to contact when a GP was away. Another example was that the nurses found that since the number of baby

immunisations increased to four in one appointment, that 10 minutes per appointment was not long enough, this was increased to 20 minutes per appointment. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local schemes to improve outcomes for patients in the area. Examples included local and national care plan schemes. The practice were part of a local federation of GP practices and two practice members sat on the board. They encouraged staff development, which motivated employees and helped with succession planning. For example one member of staff who had been a health care assistant with the practice was training as a nurse and had a placement at the practice. Another member of the reception staff was training to be a computer co-ordinator. The practice frequently held educational meetings and invited colleagues from other local health services. The practice was a GP training practice. They frequently hosted and trained trainee physicians' associates, student nurses and medical students.