# Dr Vishwambhar Sinha aka Crane Park Surgery

## Quality Report

Crane Park Surgery
Whitton Corner Health & Social Care Centre,
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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**

The Crane Park Surgery, located in Twickenham in the London Borough of Richmond upon Thames in south-west London, provides a general practice service to around 3,000 patients.

We carried out an announced comprehensive inspection on 29 October 2014. The inspection took place over one day and was undertaken by a lead inspector, along with a GP advisor. We looked at care records; spoke with patients, and staff including the management team.

Overall the practice is rated as Good.

Our key findings were as follows:

• The service is safe. There were systems in place for reporting, recording and monitoring significant events to help provide improved care. Staff were clear of their roles in regards to monitoring and reporting of incidents, safeguarding vulnerable people and children, and following infection prevention and control guidelines.

• The service is effective. Staff shared best practice through internal arrangements and meetings and also by sharing knowledge and expertise with external consultants and other GP practices. There was a strong multidisciplinary input in the service delivery to improve patient outcomes.

• The practice is caring. Feedback from patients about their care and treatment was positive. Patient feedback seen from the national GP survey 2014 was mostly positive. Patients were treated with kindness and respect and felt involved in their care decisions. Almost all of the 46 comment cards completed by patients who used the service in the two weeks prior to our inspection visit had very positive comments about the care and service provided by the surgery.

• The practice is responsive. The practice was responsive to the needs of vulnerable patients and there was a strong focus on caring and on the provision of patient-centred care. Information on health promotion and prevention, on the services provided by the practice and on the support existing in the community was available for patients. However the practice had no place for patients to make comments or suggestions within the practice. The practice did not have a Patient Participation Group (PPG).

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• The practice is well-led. The practice has a clear vision and strategic direction. Staff were suitably supported, and patient care and safety were a high priority.

All the population groups including older people; people with long term conditions; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health received care that was safe, effective, caring, responsive and well-led.

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

Importantly the provider must:

- The practice must regularly gather the views of service users, persons acting on their behalf and persons who are employed for the purposes of carrying out the regulated activity. Such as the views and comments of a Patient Participation group (PPG).

In addition the provider should:

- Consider having an Automated External Defibrillator (AED) to maximise emergency care provision available within the practice and to ensure the welfare and safety of service users.

**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 good for safe.

We found that suitable arrangements were in place for medicines management, infection control, staff recruitment, and dealing with medical emergencies. There were systems and processes in place, and staff we spoke with understood their responsibilities to raise concerns and report incidents. There was a culture of reporting, sharing and learning from incidents within the organisation. Staff were trained and aware of their responsibilities for safeguarding vulnerable adults and child protection. The equipment and the environment were well maintained, and staff followed suitable infection control practices. Vaccines and medicines were stored suitably and securely, and checked regularly to ensure they were within their expiry dates.

**Are services effective?**

Good

The practice is rated good for effective.

The practice worked with other health and social care services, and information was shared with relevant stakeholders such as the Clinical Commissioning Group (CCG) and NHS England. There were suitable systems in place for assessment of patient needs, and care and treatment was delivered in line with current legislation and best practice. Clinical staff kept up to date with best practice and guidelines, with regular updates and referencing from the National Institute of health and Clinical Excellence (NICE). NICE guidelines were used to support clinical practice and patient care. Audits of various aspects of the service were undertaken at regular intervals and changes were implemented to help improve the service. Staff were supported in their work and professional development. Information leaflets were available to patients within the waiting area. The practice leaflet was recently updated and contained useful and easy read information for patients about the location, staff and services on offer, including who to contact out-of-hours or in an emergency. Immunisation, vaccinations, smear tests, health checks and blood testing were available within the practice. The practice also offered nurse led clinics for diabetic and asthma checks.

**Are services caring?**

Good

The practice is rated good for caring.

The patients and carers we spoke with were complimentary about the care and service that staff provided and told us they were treated with dignity and respect. They felt well informed and

# Summary of findings

involved in decisions about their care. In our observations on the day we found that staff treated patients with empathy and respect. National data showed that patients rated the practice higher than others for several aspects of care for example The proportion of respondents to the national GP patient survey with a preferred GP usually get to see or speak to that GP was 92% compared to the local CCG average of 59%.

Patient's comments received said they were treated with compassion and they were involved in care and treatment decisions. We observed staff treating patients with kindness and respect ensuring confidentiality was maintained at all times. Patients' comments provided to us on the day of inspection informed us that patients were treated with kindness and respect, that they were communicated with and involved with their care, and that the service on offer was exceptional. There were systems in place to effectively manage all vulnerable patients and patients with a care plan. Patients who did not attend or missed appointments were followed up by letter or by telephone such as patients needing vaccinations and immunisations.

**Are services responsive to people's needs?**

Good

The practice is rated good for responsive.

Patients' needs were suitably assessed and met. There was good access to the service with urgent appointments available the same day. The building was modern in design, bright with large spaces and shared a reception with other health care providers and services available within the same building. The practice offered patients routine and urgent appointments Monday to Thursday and in addition was operating an open appointments clinic on a Friday for all patients. The principal GP also told us that if demand for appointments increased significantly they would provide additional hours to meet the demand.

Patient feedback was not obtained proactively, and there was no Patient Participation Group (PPG), however the practice learned from patients' experiences, concerns and complaints to improve the quality of care. For example the practice used its annual patient survey and public website feedback to monitor and improve services. The practice was responsive to the needs of the vulnerable patients, for example those who were homeless and those with disabilities. The treatment and consulting room, the reception area and the patient toilets on the first floor were wheelchair accessible and patients also had the use of a lift.

**Are services well-led?**

Good

The practice is rated good for well-led.

# Summary of findings

The practice was well-led and had a clear vision and strategy to deliver good care and service to its patients and the community. The practice vision was to provide high quality, effective treatment and advice in safe surroundings and to make the patient `s visit as comfortable and productive as possible The culture within the practice was one of openness, transparency and of learning and improvement. There was a clear leadership structure and staff felt supported by management. Risks to the effective delivery of the service were assessed and there were suitable business continuity plans in place. The staff were well supported, worked closely together and felt able to raise concerns. Meetings were undertaken regularly, and staff received suitable training and appraisals. The principal GP was the lead for safeguarding and was appropriately trained at level 3. Staff were clear about their role and responsibility and knew who to report concerns or issues to. Staff told us that they felt supported to carry out their role and were encouraged to take part in development, and to contribute to meetings and discussions.

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## 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 was responsive to the needs of older people including those with dementia. Older people were cared for with dignity and respect and there was evidence of working with other health and social care providers to provide safe care. Home visits and rapid access appointments were available for terminally ill and housebound patients.

The principal GP completed two weekly meetings with other health care providers such as health visitors and district nurses to discuss registered patients requiring care and treatment and any other patients that were of concern. All patients aged 75 years and over were specifically being cared for by a named GP, in this case the principal GP. Older people were afforded the option of home visits, and regular contact. Regular contact with these patients was completed by the lead GP who was able to demonstrate that these patients would be contacted every two months if they had not attended or had not been in contact with the practice within this time. This was usually a telephone call or a home visit and this was recorded in the patient record.

Patients in this group were provided with written notification and access to influenza vaccine appointments including follow ups for patients that did not attend the practice, and were all registered for electronic prescribing which could be requested and available on the same day. The lead GP was able to provide evidence that discussions, records and consent from patients within this group had all been collated with the practice to support them with repeat prescribing, meaning that they could have their prescription collected either at the practice or a participating pharmacists. Bereavement services were available through the principal GP, with referral to Richmond wellbeing services as required. The principal GP told us that the practice awareness of dementia prevalence was lower than the national average. The practice had low numbers of patients with dementia within the practice. The practice was monitoring this patient group to identify those who may need memory tests and onward referral to a psychogeriatrican.

**People with long term conditions**

Good

The care of patients with conditions such as cardiovascular diseases, diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD) was based on national guidance and clinical staff had the knowledge and skills to respond to their needs.

# Summary of findings

The care and medicines of patients in this group were reviewed regularly and staff worked with other health and care professionals to ensure a multi-disciplinary approach for patients with complex needs.

For example, patients with long term medication needs were monitored every 6 months to ensure blood tests and prescriptions were being managed routinely and in line with guidance, and their needs and care plans. The principal GP was clinical lead for all patients in this group. The practice was monitoring the prevalence of diabetes for all patients and for those with specific risk factors and those from ethnic backgrounds registered with the practice. The practice had a list of 145 registered patients within this group who had required review of individual care plans, blood tests and results.

The principal GP was engaged with stakeholders working jointly to provide care for terminally ill patients. The principal GP also had responsibility to registered patients housed within a local hospice with weekly visits being conducted. The practice was providing locally enhanced services jointly with other stakeholders including Macmillan nurses and the local Princess Alice hospital.

**Families, children and young people**

Good

There were suitable safeguarding policies and procedures in place, and staff we spoke with were aware of how to report any concerns they had. Staff had received training on child protection which included Level 3 for GPs and nurses. There was evidence of joint working with other professionals including midwives and health visitors to provide good antenatal and postnatal care. Patients in this group that required an urgent appointment were seen in appointment slots that were in addition to booked appointment slots. Child immunisations were provided in line with national guidelines with any non-attendance being followed up by the principal GP or nurse. Immunisations were offered and only given with consent of parents, which was recorded on the patient's record.

**Working age people (including those recently retired and students)**

Good

The needs of the working age population, those recently retired and students had been identified and there were a variety of appointment options available to these patients such as on-line booking and extended hours. The practice offered health checks, travel vaccinations and health promotion advice including smoking cessation. The practice also offered telephone consultations throughout the day during opening times. The practice nurse was responsible for patient health checks for all patients aged 40 years and above, and the practice also offered new patient health checks for all patients.

# Summary of findings

**People whose circumstances may make them vulnerable**

Good

People attending the practice were protected from the risk of abuse because reasonable steps had been taken to identify the possibility of abuse. The practice had policies in place relating to the safeguarding of vulnerable adults and whistleblowing and staff we spoke with were aware of their responsibilities in identifying and reporting concerns.

The practice provided a chaperone and advocacy service at request and could provide trained staff to support patients. Staff within the practice had good understanding of the Mental Capacity Act (MCA), and how it applied, and was able to talk us through the actions they would undertake if they had concerns for patients, relatives or their carers. The practice worked with other health and social care professionals to ensure a multi-disciplinary input in the case management of vulnerable people. The practice was signed up to the learning disability direct enhanced service (DES) to provide an annual health check for people with a learning disability to improve their health outcomes.

The principal GP was able to provide examples which included significant event reviews and actions to maintain care and treatment for vulnerable patients. The practice worked in corroboration with local health care partners and practices for this group of patients. Patient concerns or request were referred to the principal GP for approval.

**People experiencing poor mental health (including people with dementia)**

Good

The practice was signed up to the dementia local enhanced service (LES) to provide care and support for people with dementia. The services were planned and co-ordinated to ensure that people's needs were suitably assessed and met. Staff had a clear understanding of the Mental Capacity Act (MCA) and how to report any concerns and who to report them to within the practice. Reviews of care records of patients with dementia and mental health issues showed they were receiving regular reviews of their health, adequate multi-disciplinary input and support from the community mental health teams. The provider also ensured that patients within this group received regular medication and care plan reviews.

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## What people who use the service say

On the day of our inspection the practice was not open for general appointments and we were unable to speak with patients. In the two weeks prior to our inspection date and visit the CQC had provided the location with comment cards to be completed by patients and relatives visiting the practice for our attention and collection on the day of inspection.

We received 46 patient comment cards from patients who attended the practice during the two weeks before our inspection and almost all were complimentary of the care they received from the surgery staff. All of the comment cards received during the inspection visit were extremely positive about the care and treatment, and that patients were respected, cared for and said that they were treated with dignity and respect.

The practice was conducting patient surveys within the practice, recording and analysing the results to produce action points to improve care and outcomes for patients. The practice did not promote or collect comments or suggestions from people visiting the practice and did not have an active patient participation group (PPG).

The 2012/13 GP survey results showed that 86% of respondents said the last GP they saw or spoke to was good at listening to them and 76% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. Ninety six per cent of respondents said the last nurse they saw or spoke to was good at listening to them. Seventy seven percent of respondents were able to get an appointment to see or speak to someone the last time they tried, and 89% percent of the respondents said the last appointment they got was convenient. Seventy percent of respondents described their experience of making an appointment as good.

Results from the 2013/14 GP survey showed that 100% had confidence and trust in the last GP they saw or spoke to and 97% of respondents say the last GP they saw or spoke to was good at giving them enough time compared to the local average of 87%. Eighty two percent of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 87%. Ninety seven percent of respondents say the last GP they saw or spoke to was good at explaining tests and treatments compared to the local average of 88%.

## Areas for improvement

### Action the service MUST take to improve

- The practice must regularly gather the views of service users, persons acting on their behalf and persons who are employed for the purposes of carrying out the regulated activity. Such as the views and comments of a Patient Participation group (PPG).

### Action the service SHOULD take to improve

- Consider having an Automated External Defibrillator (AED) to maximise emergency care provision available within the practice and to ensure the welfare and safety of service users.

# Dr Vishwambhar Sinha aka Crane Park 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 Specialist GP Advisor. The inspection team members were granted the same authority to enter the practice as the CQC lead Inspector.

## Background to Dr Vishwambhar Sinha aka Crane Park Surgery

Dr Vishwambhar Sinha, also known as Crane Park Surgery, is located in Twickenham in the London Borough of Richmond upon Thames in south-west London, and provides a general practice service to around 3,000 patients.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostic and screening procedures, surgical procedures, treatment of disease, disorder or injury; family planning; and maternity and midwifery services at the one location.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice has a General Medical Services (GMS) contract and provides a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinic, contraception services and minor surgery. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is currently open five days a week from 9:00 am to 6:15 pm except for Wednesdays when, the practice is closed for half a day from 12:30pm. The practice has opted out for providing out-of-hours services to their patients. Out of hours services for Crane Park Surgery are provided in partnership with East Berkshire Primary Care Out-of-hours service when the surgery is closed.

The practice is one of 30 GP practices located within the Richmond Clinical Commissioning Group (CCG) which, together with the NHS England local area team, commissions care and services to a diverse population of 204,492 registered patients within the borough of Richmond.

The practice is co-located with another practice on the first floor of a new modern development, Whitton Corner Health & Social Centre. The location is modern and clean, with good access and transport links.

The practice comprises of two consulting rooms, a shared reception, waiting area, library and staff meeting room. Patients had access the 1st floor via stairs or by use of a lift.

# Detailed findings

There is a dedicated pick up and drop off point outside the building for patients with limited mobility in addition to three dedicated disabled bays. Parking is available to the practice population in the adjacent roads to the practice. CCTV monitors the shared reception area and waiting area for the safety of the patients and staff.

The practice patient list is varied in ages although adult patients 45 years of age and below make up the majority of patients registered with the practice. The practice provides approximately 80 patient appointments per day including urgent appointments.

There are nine qualified staff who work within the practice offering various services to patients including family planning, diagnostic and screening procedures, surgical procedures, maternity and midwifery services, and treatment of disease, disorder or injury. The staff team is comprised of one full time male principal GP; Two additional salaried GP's, one male and one female; one female nurse, one practice manager, and two reception/ administration staff. Crane Park Surgery medical is not a training practice.

The practice's website provides information ranging from the various services, clinic times, repeat prescriptions and location information and contact details of the practice. Staff told us that translation services were available for patients who did not have English as a first language. The GPs, phlebotomist and practice manager spoke four to five other languages in addition to English.

Phlebotomy services are also available within the practice on a Tuesday which is a contracted service provided by an alternative agency.

There were no previous performance issues or concerns about this practice prior to our inspection.

## Why we carried out this inspection

We inspected this service under section 60 of the Health and Social Care Act 2008 and as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them. We also determined which services to inspect through intelligence monitoring, public perception and engagement and partnership working with the local Care Commissioning Group (CCG).

## How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 October 2014. During our visit we spoke with a range of staff (GP partners, practice manager and the administrative and reception staff), We observed interaction between staff and visitors in the waiting room. We reviewed 46 comment cards where patients shared their views and experiences of the service. We looked at a range of records, documents and policies.

The overarching view from comments received was that patients trusted the practice GP's and staff, felt confident in the care and treatment on offer and that they were treated with kindness, respect and dignity.

Good

# Are services safe?

## Our findings

Safe track record

The practice had a good track record for maintaining patient safety. The practice manager told us of the arrangements they had for receiving and sharing safety alerts from other organisations such as the Medicines and Healthcare Products Regulatory Authority (MHRA) and NHS England. The practice had a policy and a significant event toolkit to report the incidents and the principal GP showed us the processes around reporting and discussions of incidents. Significant events were reviewed regularly and staff we spoke with were aware of identifying concerns and issues and reporting them appropriately. The provider had policies and procedures in place for safeguarding, infection control and health and safety. Consent was always requested of patients prior to any treatment or care giving and was recorded within the patient's notes and electronic records. The practice was extremely proud of the fact that it had not received a formal complaint in over two years.

Learning and improvement from safety incidents

The practice had an effective system in place for reporting, recording and monitoring incidents and significant events. There was evidence of learning and actions taken to prevent similar incidents happening in the future. For example, where a vulnerable patient had become unstable and excluded from care within the local care community, the principal GP was able to offer his services, apply strategies and patient focused meetings with other health providers to affect a positive outcome for the patient. This resulted in an agreed care plan and access to the GP services on a regular basis, The principal GP was able to share what lessons had been learnt and how the practice had changed. Records showed evidence of discussion and learning, and staff we spoke with were aware of the significant event reporting protocols and knew how to escalate any incidents. They were aware of the forms they were required to complete and knew who to report any incidents to at the practice.

Reliable safety systems and processes including safeguarding

The practice had policies in place relating to the safeguarding of vulnerable adults, child protection and whistleblowing. The principal GP was the designated lead for safeguarding. Staff we spoke with were aware of their duty to report any potential abuse or neglect issues. Clinical staff including the GPs and the nurse had completed Level 3 child protection training and the reception staff had received Level 1 training during April 2014. Staff had also received training in safeguarding of vulnerable adults and clinical staff were required to have a criminal records (now the Disqualification and Barring Service) check. The contact details of the local area's child protection and adults safeguarding departments were accessible to staff if they needed to contact someone to share their concerns about children or adults at risk. The practice had an up to date chaperone policy in place which provided staff with information about the role of a chaperone and staff were aware of their role and responsibilities. Practice staff who provided chaperone services were all DBS checked.

Medicines management

The practice had procedures in place to support the safe management of medicines. Medicines and vaccines were safely stored, suitably recorded and disposed of in accordance with recommended guidelines. We checked the emergency medicines kit and found that all medicines were in date. The vaccines were stored in suitable fridges at the practice and the practice maintained a log of temperature checks on the fridge. Records showed all recorded temperatures were within the correct range and all vaccines were within their expiry date. Staff were aware of protocols to follow if the fridge temperature was not maintained suitably. No Controlled Drugs were kept on site.

GPs followed national guidelines and accepted protocols for repeat prescribing. Prescription documentation was used in a safe and secure manner, with prescription pads being secured safely when not required. All prescriptions were reviewed and signed by GPs. Medication reviews were undertaken regularly and GPs ensured appropriate checks had been made before prescribing medicines. The principal GP was benchmarking prescribing activity by completing regular audit cycles every 2-3 months to improve and reduce prescribing activity within the practice and in line with national and local requirements.

Cleanliness and infection control

Effective systems were in place to reduce the risk and spread of infection. There was a designated infection prevention and control lead for the practice. Staff had received training in infection prevention and control and

Good

# Are services safe?

were aware of infection control guidelines. Staff told us they had access to appropriate personal protective equipment (PPE), such as gloves, aprons and spills packs. The location was visibly clean and spacious. There was a cleaning schedule in place to ensure each area was cleaned on a regular basis. Cleaning schedules were recorded and checked by the practice manager and lead GP for completion. Waste including sharps was disposed of appropriately. Hand washing sinks, hand cleaning gel and paper towels were available in the consultation, treatment rooms and toilets. Equipment such as blood pressure monitors, examination couches and weighing scales were clean. Clinical waste was collected by an external company and consignment notes were available to demonstrate this.

We found the location and premises to be clean and free from clutter. There was an infection control policy and procedure in place; Records we saw demonstrated that all staff had attended infection control training. We saw that a daily cleaning schedule was in place and we were able to view records of completed daily and weekly cleaning schedules. Clinical equipment and furniture was clean and well maintained. Infection control audits were completed annually which we were able to see had been completed in August 2014.

Equipment

There were appropriate arrangements in place to ensure equipment was properly maintained. These included annual checks of equipment such as portable appliance testing (PAT) and calibrations, where applicable. These tests had last been completed in June 2014. The fire alarm and panic alarms within the practice were tested on a weekly basis.

Staffing and recruitment

A staff recruitment policy was available and the practice was aware of the various requirements including obtaining proof of identity, proof of address, references and completing health checks and criminal records checks before employing staff. We looked at a sample of staff files and found evidence of appropriate checks having been undertaken as part of the recruitment process.

Rotas showed safe staffing levels were maintained and procedures were in place to manage planned and unexpected absences. The practice manager also told us that the practice was able to maintain staffing levels by dual working across roles when needed.

All practice staff were provided with an annual review with the principal GP. However not all of these had been completed for GP's during 2014 on the day of our visit, but were scheduled to be completed by the end of December 2014.

Monitoring safety and responding to risk

The practice manager explained the systems that were in place to ensure the safety and welfare of staff and patients. Risk assessments of the premises including trips and falls, Control of Substances Hazardous to Health (COSHH), security, and fire had been undertaken. Regular maintenance of equipment was undertaken and records showing annual testing of equipment and calibration were available. The reception area could only be accessed via lockable doors to ensure security of patient documents and the computers.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to deal with on-site medical emergencies. All staff received training in basic life support which was last completed in October 2014. The practice had available a supply of emergency medicines and equipment such as oxygen, masks, nebulisers and pulse oximeter, and these were checked regularly. However the practice did not have an automated external defibrillator (AED) to support patients in the event of an emergency.

A business continuity plan was available and the practice manager told us of the contingency steps they could undertake if there would be any disruption to the business model, the premises' computer system, and telephone lines.

Staff had access to panic alarms which were available to all staff and within all consultation rooms.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

Effective needs assessment

The practice had appropriate systems and processes in place for identifying and managing patient assessments. The GPs reviewed incoming guidelines such as those from the National Institute for Health and Care Excellence (NICE) and the clinical commissioning group (CCG). Where relevant new guidelines were discussed in practice clinical meetings. Clinical staff demonstrated how they accessed NICE guidelines and used them in practice. There were documented minutes of planned meetings and evidence of a good working relationship between the professionals to ensure information was cascaded suitably and adapted accordingly.

The principal GP had responsibility for all patients over 75 years of age, patients with learning difficulties and those that had been identified as vulnerable. There were systems in place for patients who were a risk such as house bound patients to be monitored and contacted regularly to maintain care plans and treatment. There was evidence that staff shared best practice via internal arrangements and meetings. The principal GP had responsibility for patient referrals, which were reviewed on request of other practice clinical staff to decide the best option for assessment and treatment for patients as required.

As part of the unplanned admissions Directed Enhanced Service (DES), care plans had been put in place for patients at risk to avoid unplanned admissions to hospital. Unplanned admissions and enhanced services were subject to regular monitoring and also review of medications usage and prescribing for all patients aged 75 and above. GPs are contracted to provide core (essential and additional) services to their patients. The extra services they can opt to provide on top of these are called Enhanced Services. One of the types of enhanced service is Directed Enhanced Service (DES) where it must be ensured that a particular service is provided and planned nationally for the population.

Management, monitoring and improving outcomes for people

The practice had systems in place to monitor and manage outcomes to help provide improved care. GPs and the practice manager were actively involved in ensuring important aspects of care delivery such as significant incidents recording, child protection alerts management, referrals and medicines management were being undertaken suitably.

Clinical audits such as audit of prescribing of antibiotics had been undertaken by the practice to monitor their compliance with current guidance. The Richmond clinical commissioning group (CCG) asked practices to complete auditing and analysis for certain types of antibiotics (cephalosporin's and quinolones). The practice performed a clinical system search to interrogate and look at the prescribing for two separate three-month periods in each year for antibiotic prescriptions. The audit cycle took place during April to June 2013 and again during the same period in 2014.

For example the amount of quinolone and cephalosporin prescribing in the practice decreased by 3.9% and there were fewer prescriptions for these drugs in 2014 than in the previous year. This was a positive outcome. This was due to increased awareness by the doctors of the issues surrounding the use of these drugs and the plan was to continue to reduce antibiotic prescribing in general and in particular to limit the use of the aforesaid drug groups to where they are the optimal treatment for the condition.

Audits for new cancer diagnosis in the year 2013 to 2014 had been completed, identifying five new cases, four of which were made following the 'two week wait' urgent referral process for suspected cancer and one as a direct hospital admission from the practice. The audit identified that no new cases were identified after self-referral to accident or emergency. The findings of the audit concluded that appropriate care pathways were used in these cases and that the practice was operating a safe effective system.

Regular clinical meetings took place with multi-disciplinary attendance to ensure learning and to share information. There was evidence from review of care that patients with dementia, learning disabilities and those with mental health disorders received suitable care with an annual review of their health and care plan. Medicines and repeat prescriptions were issued based on nationally accepted guidelines and were stored and secured safely when not in use within the practice.

Effective staffing

All new staff were provided with an induction and we saw an induction checklist that ensured new staff were

Good

# Are services effective?

## (for example, treatment is effective)

introduced to relevant procedures and policies. The practice manager was able to evidence that staff training had been completed for all staff to ensure that they were up to date with revalidations in general practice, infection control and cleanliness, basic and advanced life support, recognising vulnerable people, safe guarding and child protection. For example basic life support and advanced life support training had been completed in March 2013, and again in October 2014.

Adult safeguarding was completed in October 2014. All staff within the practice had completed basic life support training in October 2014. Clinical staff had last completed advanced life support training in May 2013 for example. Staff we spoke with confirmed they had received the required training and were aware of their responsibilities.

There was evidence of appraisals and performance reviews of staff being undertaken which had been completed in July 2014. The practice staff requirements for qualifications and skills were subject to annual checking and we were able to see that GP revalidation requirements had been completed and were in date at the time of our inspection. There were appraisal processes for GPs and one of them had received their revalidation in January 2013. (Revalidation is the process by which doctors demonstrate they are up to date and fit to practise.) Staff we spoke with told us they were clear about their roles, had access to the practice policies and procedures, and were supported to attend training courses appropriate to the work they performed. Staff were encouraged to develop within their role and the practice manager was supportive of learning and development.

Patients had access to two male GPs and one female GP, a nurse, the practice manager and two reception/ administration staff. Practice staff were employed correctly, with the appropriate recruitment and health checks such as the criminal records check being completed and in place prior to starting work within the practice.

Working with colleagues and other services

The practice worked with other providers and health and social care professionals to provide effective care for people. There was evidence of close working relationships with hospitals in the area including Teddington Memorial Hospital and West Middlesex and Kingston Hospitals. The principal GP is a recognised general practice appraiser for the National Health Service (NHS).

The practice had regular multi-disciplinary team meetings with other professionals including palliative care nurses, community matrons, social workers, CCG pharmacist and district nurses to ensure people with complex illnesses, long term conditions, housebound and vulnerable patients received co-ordinated care. We saw that blood test results, hospital discharge letters, communications from other providers including the out of hours provider were acted on promptly. Access to health visitors for example was readily available, and they were co-located within the same building.

The principal GP was regularly meeting with a consultant psycho geriatrician for onward referral of new dementia cases and to support local patient referrals and decision making.

Information sharing

Regular meetings were held in the practice to ensure information about key issues was shared with relevant staff. The practice was actively involved in work with peers, other healthcare providers and the Richmond clinical commission group (CCG). We were told that the practice was very open to sharing and learning and engaged openly on pathways and multi-disciplinary team meetings.

The principal GP and practice manager held daily staff meetings to discuss any relevant practice or patient concerns. One of the salaried GP's told us that there were regular care and treatment discussions were held with the principal GP. Other staff working within the practice told us that they did attend regular meetings and were able to contribute, make suggestions and raise any concerns or issues that they had. There was evidence of learning from our discussions we had with all staff and further evidence corroborated by seeing documents and case files for significant events.

The practice website provided information for patients including the services available at the practice, health alerts, repeat prescriptions, opening hours and latest news. Information leaflets and posters about local services were available in the waiting area. The practice leaflet had been recently updated and included information on services, the GPs and staff, how to contact the practice, and who to contact outside of the practice opening times.

Consent to care and treatment

Good

# Are services effective?

## (for example, treatment is effective)

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Staff told us that consent was recorded on patient notes and if there were any issues they were discussed with a carer or parent. We reviewed examples of care of patients with learning disabilities and dementia and noted that standard guidelines had been used to obtain and record consent and decisions had been taken in the best interests of patients.

Clinical staff were suitably skilled and qualified to ensure best interest decisions for patients were made in an accountable way, and to ensure children were legally able to consent to treatment. Clinical staff told us that any concerns they had for a patient in relation to care and treatment and/or consent would be highlighted to the principal GP for action and support. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

There was a range of information available to patients on the practice website and in the waiting areas which included leaflets and posters providing information on the various services, asthma clinics, diabetes clinics, flu vaccinations and smoking cessation. Data showed 98.40% of patients with diabetes had regular micro albuminuria urinalysis (urine testing) to measure levels. Which is a simple test completed over two to three months that is used to support the continued treatment of patients already diagnosed as diabetic. Albumin is not normally present in urine because it is retained in the bloodstream by the kidneys. So completion of the test and its results are an important prognostic marker for kidney disease and diabetes. Micro albuminuria is also an important adverse predictor in pre-diabetes.

The GPs told us they could refer patients with obesity and eating disorders to specialist community teams. Data available to us showed that the practice was achieving about 89.45% coverage compared to the local average of 74.25% for the DTaP / Polio / Hib immunisation (Diphtheria, Tetanus, a cellular pertussis (whooping cough), poliomyelitis and Haemophilus influenza type b), Meningitis C and MMR vaccination for children. All new patients registering with the practice were offered a health check which was undertaken by the practice nurse.

Good

# Are services caring?

## Our findings

Respect, dignity, compassion and empathy

The 2013/14 GP survey results (latest results published in July 2014) showed that 85% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 90% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. Ninety two percent of respondents said the last Nurse they saw or spoke to was good at treating them with care and concern.

On the day of our inspection visit the practice was closed for appointments from 12:30pm so we were unable to speak with patients on the day of our visit.

Blood testing, repeat prescriptions and urgent appointments were available during the morning session.

Patients were requested to complete CQC comment cards in the two week prior to our inspection visit to provide us with feedback on the practice. We received 46 completed cards. Almost all the comment cards we received had very positive comments about the staff and the care people had received. People told us they were very happy with the medical care and treatment at the practice. They stated that the GPs were caring, that they were treated with dignity and respect. and that they were happy with the principal GP, the staff and the practice in general for the care, treatment and availability of appointments

The practice phones were located and managed at the reception desk. The reception desk was enclosed by a glass window which ensured privacy of telephone calls being managed. Patients could be spoken to in private and away from the main reception area on request. The reception within the waiting room was shared with another provider within the same building but was designed to clearly signpost patients into the correct area for consultation and treatment.

A notice setting out chaperoning arrangements was displayed within the waiting area. GP and nurse consultations were undertaken in consulting rooms, which ensured privacy for patients. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Disposable curtains were provided so that patients' privacy and dignity was maintained during examinations Staff we spoke with were aware of the need to be respectful of patients' right to privacy and dignity. We observed staff interactions with visitors in the waiting area and at the reception desk and noted that staff ensured respect and dignity at all times.

Care planning and involvement in decisions about care and treatment

In the 2014 national patient survey, 91% of the respondents gave a score of 4 or 5 (on a scale of 1-5, where 5 was agree; 1 disagree) in response to the question 'I am confident in the care given to me by the doctors and nurses'. Eighty three percent of the respondents gave a score of 4 or 5 in response to the question 'The doctors involve me in decisions about my care' and 84% of the respondents gave a score of 4 or 5 in response to the question 'The reception staff are helpful and friendly'. This survey identified improvements were required in regard to access to appointments, which was below the local average; however feedback received through comment cards rated access to appointments as good on the day of our visit.

During our inspection visit we were unable to speak directly with patients or relatives attending the practice. However in the 2 weeks before our visit patients were asked to complete comments cards for us to review and collect on the day of inspection.

Patients and visitors who attended the practice were provided with appropriate information and support regarding their care and treatment. Healthcare leaflets were available for patients, and posters with healthcare information were displayed in the waiting area and consultation rooms.

Patient/carer support to cope emotionally with care and treatment

The practice offered patients information as to what to do in time of bereavement. The principal GP and practice manager showed told us that where relevant they could signpost people to support and counselling facilities in the community following a bereavement.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had systems in place to maintain the level of service provided. The practice held information about those who needed extra care and resources such as those who were housebound, people with dementia and other vulnerable patients. This information was utilised in the care and services being offered to patients with long term needs. Examples of which were home visits and longer appointments and telephone consultations if patients were unable to attend the practice or required more time with the GP. We reviewed a sample of care records and found that people with long term conditions such as diabetes, and those with learning disabilities, dementia and mental health disorders received regular medicines review and also an annual review of their care.

The practice did not have a system to gather patient comments or suggestions and had not set up a Patient Participation Group (PPG). Practice feedback from patients was obtained through the GP national survey and this was used to improve services. For example 84% were satisfied with the helpfulness of the receptionists. Action taken by the practice in relation to this score was to remind receptionists to be mindful of the needs of patients and to react positively to patient requests. Other evidence seen of actions taken; have been for the practice to employ more doctors to increase availability of appointments, and to Have an open appointments list so that anyone who needs an appointment will be scheduled for it if possible.

The practice had multi-disciplinary meetings with external professionals to discuss the care of patients including those receiving end-of-life care, new cancer diagnoses and also safeguarding issues, significant events, unplanned admissions and A&E attendances.

The practice was completing regular audits to support care of patients with long term conditions, an example of which is in medication reviews and usage and indicative of prescribing incentive schemes to enhance and educate patients using long term medications.

Tackling inequity and promoting equality

There were arrangements to meet the needs of the people for whom English was not the first language. Staff told us they could arrange for interpreters and also could use online resources to help with language interpretation. Staff at the practice also spoke additional languages to English including Arabic.

The practice demonstrated an awareness and responsiveness to the needs of those whose circumstances made them vulnerable. Facilities included an induction loop on the reception desk for patients with hearing disability, a lower reception desk for people in wheelchairs, access to the practice by lift and accessible toilets. Baby changing facilities were available as well.

We were told that longer appointments could be scheduled for patients with learning disabilities or as needed within the practice population list. Review of care for people with learning disabilities showed that they were receiving suitable care and had received an annual review within the last year.

There was an open policy for treating everyone as equals and there were no restrictions in registering. Homeless people, travellers and asylum seekers could be registered and seen without any discrimination.

Access to the service

The surgery had clear, obstacle free access with fully automated opening doors. Doorways and hallways were wide enough to accommodate wheelchairs of all sizes. The practice was located on the first floor of the building with direct access into the practice either by stairs or lift. The waiting area was large and spacious, and had suitable seating with a good amount of seats. The practice had a GMS contract and provided a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinic, contraception services and surgical procedures.

The practice was currently open four and a half days a week not including weekends from 9:00 am to 6:15 pm. The practice was closed one half day a week from 12:30 pm on a Wednesday and had nurse led appointments every Tuesday and Thursday from 9:00 am till 6:15pm. The practice maintained a basic user-friendly website with information available for patients including the services provided, contact details, booking appointments and ordering repeat prescriptions. There were various information leaflets providing meaningful and relevant information on various conditions, health promotion, support organisations and alternative care providers within

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

the practice waiting area. The practice also provided walk in appointments open to all patients one day a week and in addition to scheduled appointments. The principal GP told us that the practice operated an open door policy and all his staff and services were available on request and dependent on immediate needs and urgency.

Appointments could be booked by phone, and in person. The practice had responded to people's concerns and had introduced changes in the telephone booking systems to improve accessibility.

Most patients we spoke with were happy with the appointments system currently in place. They said appointments were easy to get and were available at a time that suited them.

Staff told us that for urgent needs patients could be seen by a doctor on the same day. They told us that children and elderly patients were given priority and were seen the same day by the GP. The GP's were contactable outside of appointment times for telephone consultations, and the principal GP was providing direct care services to all patients over 75 years of age or diagnosed with cancer or that were vulnerable. Telephone consultations could be accessed outside of surgery times, and were provided all day on a Friday in addition to normal practice services and appointments. The practice policy was to see all mothers, babies and children in addition to scheduled appointment slots providing additional urgent appointments as needed.

Information was available via the practice leaflet, the telephone answering message and the practice's website, providing the telephone number people should ring if they required medical assistance outside of the practice's opening hours.

Listening and learning from concerns and complaints

The practice had effective arrangements in place for handling complaints and concerns. The practice had a complaints handling procedure and the practice manager was the designated staff member who managed the complaints. The practice manager was very open to learning from concerns or complains and was able to show us that the practice had not received any complaints in over two years.

# 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 vision strategy and statement of purpose which outlined the practice's aims and objectives and laid out patients' responsibilities as well as their rights. All the staff we spoke with described the culture as supportive, open and transparent. The receptionists and all staff were encouraged to report issues and patients' concerns to ensure these could be promptly managed.

Staff we spoke with demonstrated an awareness of the practice's purpose and were proud of their work and team. Staff felt valued and were signed up to the practice's progress and development. The practice patient list has grown over the past year to over 3000 patients which the principal GP believed could be increased by a further 500 without impacting on services already available.

Governance arrangements

The practice had good governance arrangements and an effective management structure. The principal GP having last updated his information governance skills in February 2013. Appropriate policies and procedures, including human resources policies were in place, and there was effective monitoring of various aspects of care delivery. We looked at a sample of these policies which were all up to date and accessible to staff.

The practice manager had an important role within the practice and the services on offer, and during discussions in relation to record keeping and documentation, appreciated that some areas of their business such as staff meetings could be evidenced better. The practice audits were used to improve services and understanding of better patient care. All practice clinical audits were being assessed for associated risks such as prescribing levels and by re auditing over two cycles, again with any changes or recommendations being implemented as required. Patient's records were stored securely in both hard copies and electronic files.

Staff were aware of lines of accountability and who to report to. The practice had regular meetings involving GPs, practice manager and receptionists. Monthly meeting minutes showed evidence of good discussions of various issues facing the practice. The lead GP was able to explain the importance of maintaining governance structures.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing mostly in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. Meeting documents we saw confirmed that QOF data was a regular meeting item with any comments, concerns or actions documented.

There was a culture of learning and auditing and a number of clinical audits had been completed for example on antibiotic prescribing.

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

Leadership, openness and transparency

The practice was led by the principal GP and the practice manager. There were systems in place to for monthly clinical meetings which were recorded and documented. Discussions were held daily with staff. Staff meeting minutes we did see showed team working and effective, inclusive leadership. There was a clear leadership structure which had named members of staff in lead roles. For example the nurse was the lead for infection control and the principal GP was the lead for safeguarding. We spoke with five 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.

We saw from minutes that practice team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

There was evidence of learning from events which the principal GP was able to show us with actions and outcomes that were implemented, and that benefited patient care. The principal GP had completed leadership training, and used this skill to support staff and best practice working.

# Are services well-led?

Good

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

The lead GP was also an appraiser for GP services within the wider National Health Service (NHS) and was able to make recommendations, share information and best practice advice to colleagues through this process.

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

We found the practice to be involved with their patients, and other stakeholders. The practice was engaged with the Richmond clinical commissioning group (CCG), the local health and care network and peers. We found the practice open to information sharing, learning and engaged openly in multi-disciplinary team meetings.

We found evidence that the practice responded to national patient survey results as was evidenced by the changes made to availability of GP's and appointments. The practice manager showed us the analysis of the last national patient survey which was considered before action was taken.

Staff were supported in their professional and personal development. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff did tell us that they all contributed to meetings and were encouraged to raise concerns directly with the practice manager or principal GP at all times. Staff also told us they had attended courses and skills updates according to their roles and responsibilities and were outwardly keen and encouraged to develop skills and further professional development with the support of the principal GP. The practice had a whistle blowing policy which was available to all staff.

There was no patient participation group (PPG) at the practice. There was also no place for patients to make comments or suggestions within the practice. On the day of our inspection we received 46 patient comment cards that had been completed in the two weeks prior to our visit. All of the 46 comment cards gave a positive response for the lead GP, the practice and its staff. The practice did use findings from the 2014 national patient GP survey and these were shared practice wide with action points and learning included. Some of these had been acted upon to change best practice and services at the practice.

Management lead through learning and improvement

The practice had systems and processes to ensure all staff and the practice as a whole learnt from incidents and significant events, patient surveys and complaints to ensure improvement. The GPs provided peer support to each other and also accessed external support to help improve care delivery.

Staff attended courses and skills updates according to their roles and responsibilities and were outwardly keen and encouraged to develop skills and further professional development with the support of the principal GP. All practice staff were subject to an annual review with the principal GP, although not all of these had been completed for the GP's within the practice during our inspection visit, with two further annual reviews to be completed before the end of December 2014.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings to ensure the practice improved outcomes for patients The practice manager told us that, regular staff meetings for all practice concerns were completed daily. Records and evidence of incidents and significant events were available to us to see during our inspection visit.

The lead GP told us that he used his experience and knowledge to improve the quality of services available within the practice. Systems, tools and information were used to support best practice, care and treatment. National guidelines such as those from the National Institute for health and Care Excellence (NICE) were used to support decision making and patient care.