

# Glebe Road Surgery - Botting

## 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?

Outstanding 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Glebe Road Surgery on 2 August 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.
- Overall, risks to patients were assessed and well managed; however, the practice did not have an up to date fire risk assessment.
- The practice was clean and tidy. The practice informally monitored the performance of the cleaner, who was employed via an external company; however, there was no cleaning schedule or record of cleaning carried-out.
- 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 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.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.
- 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 two areas of outstanding practice:

# Summary of findings

The practice provided joint consultations with psychiatrists in order to provide an enhanced level of care to patients with mental health needs, whose conditions were difficult to manage, but were not sufficiently severe to meet the criteria for hospital referral; they had provided this service to seven patients since 2012, and on average had provided approximately three appointments of this kind per patient. Where appropriate, these appointments had been provided in the patient's home. In each case a tailored care plan had been developed for the management of the patient's condition.

The practice showed a strong commitment to contributing to the future of general practice and was a learning hub for a broad spectrum of roles, both clinical and non-clinical. This involved providing training placements for medical students, foundation year doctors (including "trainees in difficulty"), GP registrars, and for student nurses. They also provided training opportunities to allied health professionals such as physiotherapists and paramedics, and to specialist

doctors such as dermatology registrars. The practice had also participated in the pilot scheme for training physician associates. In addition to training clinical staff, the practice also provided work experience placements for school students and apprenticeship placements. The practice produced its own resources to support its trainees, such as personal induction booklets and tailored work books.

The areas where the provider should make improvement are:

- They should ensure that their business continuity plan is reviewed and updated.
- They should update their fire risk assessment and risk mitigation plan.
- They should put in place a cleaning schedule, outlining the cleaning tasks required, and ensure that a record is made of the cleaning completed.

**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.

Good



- There was a system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice; however, the recording of discussions about significant events in meetings was not sufficiently detailed to enable a member of staff who was not present at the meeting to benefit from the learning.
- 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.
- Overall, risks to patients were assessed and well managed; however the practice had failed to keep their fire risk assessment up to date.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. For example, following new evidence which suggested that 'flu vaccinations were more effective when administered in the morning, they were planning to deliver flu clinics starting at 7am for the 2016 'flu season.
- 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.

# Summary of findings

- There was evidence of appraisals and personal development plans for all staff.

## 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 several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



## 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. The practice was an active member of the Richmond GP Alliance, and they participated in the “amber warning” scheme to report problems with local processes which could impact on patient safety.
- The practice used innovative and proactive methods to improve patient outcomes, and worked with other local providers to share best practice. For example, they provided joint consultations with a psychiatrist to patients whose conditions were difficult to manage but who did not meet the criteria for hospital treatment. They had also had dermatology registrars complete a placement at the practice as part of their training and could describe ways in which both the practice and the registrars benefitted from each-other's expertise.
- 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 the morning walk-in clinic and book on the day appointments.
- 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.

Good



# Summary of findings

## Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients; the strategy was regularly reviewed by the management team. 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.
- High standards were promoted and owned by all practice staff, and teams worked together across all roles.
- 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 this information was shared with staff to ensure appropriate action was taken; however, minutes of meetings were not sufficiently detailed to allow staff who had not attended the meeting to benefit from the learning.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice proactively sought feedback from staff and patients, which it acted on. It had a very engaged patient participation group which influenced practice development.
- There was a strong focus on continuous learning and improvement at all levels, with a particular focus on contributing to the future of general practice by offering teaching placements for both clinical and non-clinical staff. Staff at the practice also had additional interests and expertise which enhanced the service provided to patients. For example, one of the partners was the Royal College of GPs clinical champion for minor surgery, another partner sat on the national advisory committee for sepsis, and others had completed additional training in specialisms such as dermatology, ophthalmology and orthopaedics. Several of the partners were Darzi fellows (a prestigious clinical leadership scheme).

**Outstanding**



# 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.
- The practice had planned and delivered a successful 'flu campaign, where they encourage uptake by contacting patients by text, telephone and letter, and specifically wrote to all patients who had newly turned 65 years, who may not have been aware that they were entitled to the vaccine.
- For patients at risk of unplanned admission, summarised medical records were provided to the out of hours provider to ensure continuity of care.

Good



### People with long term conditions

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

- Nursing staff had lead roles in chronic disease management, including anti-coagulation, diabetes care (including insulin initiation), and respiratory conditions; patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators were better than the CCG and national average. Overall the practice achieved 100% of the total QOF points available, compared with an average of 90% locally and 89% nationally.
- 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.

Good



### Families, children and young people

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

Good



# Summary of findings

- 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 relatively high 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.
- Cervical screening had been carried-out for 85% of women registered at the practice aged 25-64, which was comparable to the CCG average of 84% and national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

## **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 as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice sent appointment reminders and health promotion information by text message.

**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.

- 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.

**Good**





# Summary of findings

- 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.

## 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).

- The practice had 65 patients diagnosed with dementia and 84% of these patients had had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG average of 86% and national average of 84%.
- The practice had 58 patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses, and had recorded a comprehensive care plan for 98% of these patients, compared to a CCG average of 94% and national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They also provided joint consultations with psychiatrists in order to provide an enhanced level of care to patients with mental health needs whose conditions were difficult to manage but were not sufficiently severe to meet the criteria for hospital referral.
- 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.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia, including providing care to residents of a local care home. Staff had completed training to become "Dementia Friends" in order to gain an enhanced awareness of the issues affecting patients with dementia.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing better than local and national averages. Two hundred and ninety six survey forms were distributed and 119 were returned. This represented approximately 1% of the practice's patient list.

- 94% of patients found it easy to get through to this practice by phone compared to the CCG average of 78% and national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 79% and national average of 76%.
- 94% of patients described the overall experience of this GP practice as good compared to the CCG and national average of 85%.

- 92% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 82% and national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards which were all positive about the standard of care received. Patients commented that staff are always caring and helpful and that appointments are never rushed.

We spoke with nine patients during the inspection. All nine patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

# Glebe Road Surgery - Botting

## 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, a practice manager specialist advisor and an expert by experience.

## Background to Glebe Road Surgery - Botting

Glebe Road Surgery provides primary medical services in Barnes to approximately 9500 patients and is one of 29 practices in Richmond Clinical Commissioning Group (CCG).

The practice population is in the second least deprived decile in England. The proportion of children registered at the practice who live in income deprived households is 7%, which is lower than the CCG average of 9%, and for older people the practice value is 11%, which is the same as the CCG average. The practice has a smaller proportion of patients aged 20 to 34 than the CCG average. Of patients registered with the practice, the largest group by ethnicity are white (88%), followed by asian (5%), mixed (4%), black (1%) and other non-white ethnic groups (2%).

The practice operates from a 2-storey converted residential premises. Car parking is available in the surrounding streets. The reception desk, waiting area, a number of GP consultation rooms, and the nurse and healthcare assistant consultation rooms are situated on the ground floor. Further consultation rooms are available on the first floor, which is accessible by both a flight of stairs and a lift. The practice has access to 10 doctors' consultation rooms, one minor surgery room, and two nurse consultation rooms.

The practice team at the surgery is made up of one full time and one part time male GPs and one full time and three part time female GPs who are partners, one full time male salaried GP, one female GP registrar and two foundation year 2 doctors (one male, one female), and one female physician assistant; in total 49 GP sessions are available per week. In addition, the practice also has two part time and one full time female nurses and one full time female healthcare assistant. The practice team also consists of a practice manager, assistant practice manager, six receptionists, two administrators and two secretaries.

The practice operates under a General Medical Services (GMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice is open between 8:30am and 6:30pm Monday to Friday. Extended hours surgeries are offered between 6:30pm and 7pm on Mondays, Tuesdays and Thursdays, and until 7:50pm on Wednesdays; and early morning appointments are available from 7:10am on Tuesday mornings. Patients can also access appointments via the CCG seven-day opening Hub, which offers appointments from 8am until 8pm every day at a nearby practice.

When the practice is closed patients are directed to contact the local out of hours service.

The practice is registered as a partnership with the Care Quality Commission to provide the regulated activities of diagnostic and screening services; maternity and midwifery services; treatment of disease, disorder or injury; surgical procedures; and family planning.

# 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 2 August 2016. During our visit we:

- Spoke with a range of staff including GPs, nursing staff, the practice manager and administrative 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. We viewed four examples of significant event records, and noted that there were inconsistencies in the templates used; we were told that the practice had recently changed their process and was now using a database system for recording significant events, but it was unclear whether this change in process had been communicated to all staff. However, all staff we spoke to, both clinical and non-clinical, were able to give an example of a recent significant event that they had either reported or that had been shared with them in a team meeting. The incident recording process 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 the significant events, and we saw one example of an audit being carried-out as a result of a significant event relating to a medication change request for a patient in a care home being missed.

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, following an incident where a two-week-wait cancer referral was missed, a review of the process was conducted and a new process was put in place.

### 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; staff were able to provide recent examples of safeguarding referrals that they had made. GPs were trained to child protection or child safeguarding level 3, nurses were trained to level 2, and non-clinical staff and the healthcare assistant were trained to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. Nursing staff acted as chaperones and had received a 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. The practice was cleaned by an external contractor who attended every evening; however, there was no cleaning schedule which listed and recorded completion of the cleaning tasks required. The senior practice nurse had been the infection control clinical lead and was in the process of handing this responsibility to one of the practice nurses; the senior practice nurse was a member of the Infection Protection Society and attended lectures on current practice, which she fed back to colleagues at the practice. There was an infection control protocol in place and nursing staff delivered in-house training sessions to staff on various aspects of infection control. Nursing staff had also produced an infection control workbook, which was provided to all staff. 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,

## Are services safe?

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 practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored; the practice had recently developed a protocol for the storage and monitoring of these, and we saw evidence that systems were being put in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment, in line with the practice's recruitment policy. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We noted that the practice's recruitment policy did not specifically cover the pre-employment checks that would be carried-out on locums; however, we were informed by the practice that locum staff were subject to the same checks as permanent staff, and we saw evidence that appropriate checks had been carried-out on the three locum GPs that the practice had employed in the past two years.

### 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 with a poster in the reception office which identified local health and safety representatives. The practice's most recent fire risk assessment had been completed in 2011 during which a major building project was being undertaken in order to extend the premises. The actions highlighted by the risk assessment relating to the premises were addressed as

part of the build, and the finished building had been deemed compliant with fire regulations; however, the practice did not have a current fire risk assessment and mitigation plan. Regular tests of the fire alarm and annual fire evacuation drills were carried-out. 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).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

### 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.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- 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 a business continuity plan in place for major incidents such as power failure or building damage; however, this plan had not been updated for several years and some information contained in it was out of date.



# 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.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- All referrals to secondary care made by the practice were reviewed by GPs in clinical meetings to ensure that these were appropriate.
- The practice took into consideration evidence based guidance and standards when considering how to deliver their service. For example, following new evidence which suggested that 'flu vaccinations were more effective when administered in the morning, they were planning to deliver flu clinics starting at 7am for the 2016 'flu season.

### 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 were 100% of the total number of points available. The practice's overall clinical exception rate was 5%, which was below the CCG average of 7% and national average of 9%. (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 2014/15 showed:

- Performance for diabetes related indicators were better than the CCG and national averages. Overall the practice achieved 100% of the total QOF points available, compared with an average of 90% locally and 89%

nationally. The proportion of diabetic patients who had a record of well controlled blood pressure in the preceding 12 months was 88%, which was better than the CCG average of 79% and national average of 78%; the proportion of diabetic patients with a record of well controlled blood glucose levels in the preceding 12 months was 86%, compared to a CCG and national average of 78%; and the proportion of these patients with a record of a foot examination and risk classification in the preceding 12 months was 94%, compared to the CCG average of 90% and national average 88%.

- Performance for mental health related indicators was comparable to CCG and national averages. The practice had 65 patients diagnosed with dementia and 84% of these patients had had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG average of 86% and national average of 84%. The practice had 58 patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses, and had recorded a comprehensive care plan for 98% of these patients, compared to a CCG average of 94% and national average of 88%.

The practice had planned and delivered a 'flu campaign, aimed at ensuring that patients who were entitled to a 'flu vaccination received one. In order to encourage uptake, they had contacted patients by text, telephone and letter, and had specifically written to all patients who had newly turned 65 years, who may not have been aware that they were entitled. In addition to this, they also ran an advertisement in the local community magazine. As a result, they achieved a 76% uptake compared to a CCG average of 49%.

There was evidence of quality improvement including clinical audit.

- There had been 14 clinical audits completed in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, the practice had identified that it was good practice for a record to be made in the consultation notes of the identity of any adult who accompanied a

# Are services effective?

## (for example, treatment is effective)

child to an appointment, and they therefore decided to audit compliance with this. The initial audit found that over a two day period 28% of consultations with children had a record in the notes of the relationship of the accompanying adult. This outcome was discussed in a practice meeting, and following this a re-audit was conducted over a further two day period which found that information about the accompanying adult was recorded for 80% of consultations.

### Effective staffing

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

- The practice produced an individually tailored induction programme for all newly appointed staff, and online training sessions were available for new staff which covered such topics as safeguarding, 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. The healthcare assistant had received training in order to run the in-house anti-coagulation clinic; the senior practice nurse had qualified as a diabetes specialist and ran the practice's diabetic clinic, including insulin initiation; and one of the practice nurses was receiving specialist training in managing respiratory 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, discussion at practice meetings, and attending practice nurse forums.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. 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. All staff had received an appraisal within the last 12 months.
- 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. Records were kept of the training sessions that staff had completed; however, there was not one central training record for all staff (for example, records for nursing staff were kept by the senior nurse, whereas the practice manager kept records for non-clinical staff and GPs), and there was no clear system for flagging when mandatory training was due. This was discussed during the inspection, and the practice manager committed to making this process more robust.

### 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. Meetings took place with other healthcare professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice provided summaries of notes for patients on their "avoiding unplanned admissions" register to their out of hours provider to ensure continuity of care.

### 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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.



# Are services effective?

(for example, treatment is effective)

- 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.

## 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.
- A dietician was available on the premises and smoking cessation advice was available from the healthcare assistant.

The practice's uptake for the cervical screening programme was 85%, which was comparable to the CCG average of 84% and the national average of 82%. The practice encouraged uptake of the screening programme by ensuring that a female sample taker was available. There were failsafe 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. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Their uptake for these tests was comparable with CCG and national averages, with the exception of the proportion of patients who were screened for breast cancer within six months of invitation, which was 38% compared to a CCG average of 69% and national average of 73%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 74% to 98% (CCG averages ranged from 82% to 94%) and five year olds from 73% to 95% (CCG averages ranged from 69% to 94%).

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 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 37 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 three 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:

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) and national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.

- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and 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.

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 in line with local and national averages. For example:

- 93% 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%.
- 91% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 94% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

### 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. This information was clear and well organised. Information about support groups was also available on the practice website.

## Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 201 patients as carers (approximately 2% of the practice list). Health checks and flu immunisations were available for these patients; staff could also provide examples of situations where the needs of carers were considered, for example, when carers brought samples to the practice for testing, staff would

ensure that these were tested as a priority to limit the length of time that the carer had to leave the person that they cared for. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

# 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. The practice was an active member of the Richmond GP Alliance; they also participated in the "amber warning" scheme to report problems with local processes which could impact on patient safety.

- The practice offered a 'Commuter's Clinic' every weekday evening apart from Friday, and on Tuesday mornings for working patients who could not attend during normal opening hours.
- There were longer appointments available 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 all patients via the practice's morning walk-in service; the practice committed to see all patients who attended the walk-in service, and had flexible resources in place to ensure that they could provide this service effectively.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately. The practice was a registered yellow fever centre.
- There were disabled facilities, a hearing loop and translation services available.
- Every patient had a named GP; however, they did not have to see their designated GP. GPs at the practice had training in additional specialisms, such as orthopaedics, ophthalmology, dermatology and family planning, and nursing staff had specialisms in diabetes, respiratory conditions and hypertension; reception staff were able to book patients with the most appropriate clinician to address the condition they were presenting with.
- Nurse-led in-house clinics were provided for patients with long-term conditions, with an enhanced level of service which avoided patients having to attend hospital for tests and treatment. For example, they offered an in-house anti-coagulation clinic, which included taking blood tests and calculating the dose of Warfarin that patients needed; the practice had 100 patients who

benefitted from this. The practice also ran a diabetic clinic for the 177 patients at the practice with diabetes, including insulin initiation; they also screening patients who were at risk of developing diabetes and provided advice to help prevent them from developing the disease. They also ran a clinic for patients with respiratory diseases such as asthma and chronic obstructive pulmonary disease (COPD), where they liaised with specialist respiratory nurses at the local specialist centre, and used the London Asthma Toolkit to engage with young people with asthma. The practice had achieved 100% of the Quality Outcomes Framework points for outcomes relating to all of these long-term conditions.

- The practice provided joint consultations with psychiatrists in order to provide an enhanced level of care to patients with mental health needs, whose conditions were difficult to manage, but were not sufficiently severe to meet the criteria for hospital referral; they had provided this service to seven patients since 2012, and on average had provided approximately three appointments of this kind per patient. Where appropriate, these appointments had been provided in the patient's home. In each case a tailored care plan had been developed for the management of the patient's condition.
- The practice cared for 27 patients in a local 38-bed care home for people who were physically frail and/or were living with dementia. The practice's physician associate conducted a weekly ward round at the home, which was accompanied by a GP once a month. In addition to routine reviews of patients, GPs also saw patients at the home as required. We received a statement from the manager of the care home, which was positive about the care provided to patients and about the availability of staff at the practice.
- The practice was keen to be involved in the local community and to provide information and advice to local people. They had provided a stand at the Barnes summer fair, where they provided information on healthy living, such as the importance of using sun screen. They also provided regular articles in the local community magazine, in collaboration with other local practices; for example, they had contributed a piece on preventing medicines waste.

### Access to the service

# Are services responsive to people's needs?

(for example, to feedback?)

The practice was open between 8:30am and 6:30pm Monday to Friday. Extended hours surgeries were offered between 6:30pm and 7pm on Mondays, Tuesdays and Thursdays, and until 7:50pm on Wednesdays; and early morning appointments were available from 7:10am on Tuesday mornings. Patients could also access appointments via the CCG seven-day opening Hub, which offers appointments from 8am until 8pm every day. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

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

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 78%.
- 94% of patients said they could get through easily to the practice by phone compared to the CCG average of 78% 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.

A designated duty doctor was available every day to undertake home visits. Requests for a home visit would be noted and the duty doctor would then speak to the patient or their carer by telephone to prioritise the visit according to clinical need. 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.
- We saw that information was available to help patients understand the complaints system.

The practice had received nine complaints in the past year and we looked at three of these in detail. In all three examples we found that the complaints were satisfactorily handled, dealt with in a timely way and with openness and transparency, and where appropriate, patients were provided with an apology. 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. For example, the practice received a complaint from the parents of a young child about the treatment provided to the child. The child had been taken to the local hospital for treatment, and the parents were also unhappy about the treatment that the child received there. The practice investigated the complaint and then worked with the hospital concerned to provide a comprehensive joint response to the parents, covering all the issues that they were concerned about.

# Are services well-led?

Outstanding



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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a clear vision and set of values, and a supporting strategy in order to implement these. The management team held away days twice per year where they reviewed the strategy, including the development of succession planning.

### 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 staff handbook had recently been developed.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. Staff at all levels were encouraged to participate in this.
- There were 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. They told us they prioritised safe, high quality and compassionate 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 and 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 the practice held regular team meetings, and we saw minutes of these.
- 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.
- 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. For example, reception staff had fed back that they did not always receive information about significant events and the learning that occurred as a result, as these were often clinical in nature and were therefore discussed at clinical meetings. As a result, a member of nursing staff was identified to act as a link between clinical and non-clinical staff, which involved them attending administrative team meetings to feed back about significant events and other clinical issues that were important for non-clinical members of staff to be aware of, and to feed back comments and issues to the clinical team. Staff told us that this process worked well and had increased their feeling of engagement in the running of 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.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG had



# Are services well-led?

Outstanding



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

approximately 12 members, and whilst they were enthusiastic about their role and felt that they worked well as a group, they were conscious that the group was not representative of the practice's patient demographic; they were therefore working with the practice to recruit additional members to a "virtual" PPG, which would allow patients who were unable to attend meetings to contribute by email. The PPG told us that they felt that their views were valued by the practice; they carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had fed back that the patient toilets were in need of refurbishment, and this work was subsequently carried-out. They had also suggested the need for the repeat prescription request box to be situated near the front door of the practice, so that slips could be delivered quickly without the patient having to walk through to reception; this was also provided.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. They also used a process mapping exercise to gather ideas from staff to address problems that had been identified. This involved posting the problem and associated issues on a large sheet of paper on a noticeboard in the staff area and providing post-it notes for staff members to contribute their thoughts on additional issues and solutions. Staff comments and ideas were then discussed in staff meetings before a proposed solution was developed. For example, staff had raised that there were problems with the way that patient specimens were being handled, which had resulted in problems both with the physical handling and around patient's expectations about how quickly they would receive test results. Following the process mapping exercise, a new process was put in place which worked well for both staff and patients.

- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged 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 pilot schemes to improve outcomes for patients in the area.

The practice showed a strong commitment to contributing to the future of general practice and was a learning hub for a broad spectrum of roles, both clinical and non-clinical. This involved providing training placements for medical students, foundation year doctors (including "trainees in difficulty"), GP registrars, and for student nurses. They also provided training opportunities to allied health professionals such as physiotherapists and paramedics, and to specialist doctors such as dermatology registrars. The practice had also participated in the pilot scheme for training physician associates. In addition to training clinical staff, the practice also provided work experience placements for school students and apprenticeship placements. The practice produced its own resources to support its trainees, such as personal induction booklets and tailored work books. They also involved patients in the teaching process, and had several who were willing to participate in mock consultations with students.

The practice's ability to provide high quality training to those placed with them was further enhanced by the individual expertise of the staff. For example, one of the partners was the Royal College of GPs clinical champion for minor surgery and had contributed to national guidance on the subject. Another partner sat on the national advisory committee for sepsis, and others had completed additional training in specialisms such as dermatology, ophthalmology and orthopaedics. Several of the partners were Darzi fellows (a prestigious clinical leadership scheme).