

Dr Antoine Sayer

Quality Report

The Richmond Green Medical 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?

Requires improvement



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 Richmond Green Medical Centre provides GP services to just approximately 2,000 patients across Richmond, Sheen and parts of Twickenham. The practice has a branch surgery in Putney but this was not visited as part of this inspection.

We carried out a short notice announced comprehensive inspection on 11 March 2015. Overall the practice is rated as good. Specifically, we found the practice to be good at providing effective, caring, responsive and well led services. It was also rated good for the services it provided for all population groups. However, the practice requires improvement for providing safe services.

Our key findings were as follows:

- We found the practice was caring. Patients said their privacy was respected, that staff spoke with them appropriately and that they received appropriate care and treatment and that the doctor or nurse explained any treatment to them clearly. Patients said the repeat prescription process worked for them.

- We found the practice was responsive to patients' needs. They used information from patient surveys, comments and complaints to improve the services provided. The practice was accessible to people with mobility problems and those who used baby pushchairs. There was a range of on the day urgent and bookable in advance appointments; home visits were provided when required. Information about how to make a complaint was displayed at the practice.
- We found the practice was effective. Clinical staff referred to best practice guidance and used local prescribing protocols. Staff had access to training, support and had an annual appraisal. Suitable systems were in place to work with other health and social care providers.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Suitable arrangements were in place for staff recruitment and infection control.

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

The provider should:

Summary of findings

- Ensure the systems in place to deal with high risk medicines as part of the repeat prescription service are clear and understood by locum GPs;
- Ensure all GPs complete regular updates in child protection with records available at the practice;
- Record multidisciplinary meetings and

- Improve information about complaints so all patients are aware of the process.

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 requires improvement for providing safe services as there were areas where it should make improvements.

The practice manager was designated to deal with and pass on national safety alerts. Systems were in place to report and monitor incidents and staff were clear about their responsibilities. Significant events were analysed and learning was identified and shared amongst all staff. Suitable policies and procedures were in place to protect vulnerable adults and children from abuse, although GPs had not completed annual updates of child protection training. Staff recruitment practices were in line with requirements. Suitable arrangements were in place for medicines management, although improvements were needed to repeat prescription processes for high risk medicines. We found the practice was clean and effective arrangements were in place for cleaning with regular checks to ensure the required standards were maintained. Staff had access to the equipment they needed to carry out their role. Arrangements were in place for responding to risk and dealing with a range of emergencies.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services.

Clinical staff referred to best practice guidance and received national and local updates. The practice followed the Clinical Commissioning Group protocols for prescribing. Staff had access to training and support to carry out their role with the exception of child protection to the required Level for clinical staff. Systems were in place for staff to have an annual appraisal. Data showed patient outcomes were at or above average for the area. Suitable systems were in place to meet and share information with other health and social care services. There was a system for new patients to receive a health check. There was a range of information leaflets in the waiting area to help patients deal with some common long term conditions and maintain a healthy lifestyle.

Good



Are services caring?

The practice is rated good for providing caring services.

Patients said they were treated with respect and felt staff maintained their privacy and dignity. We saw staff spoke politely and appropriately to patients. Patients said they were involved in decisions about their care and treatment. Results from the 2014 GP survey showed 92% of respondents said that the last GP they saw or

Good



Summary of findings

spoke to was good at involving them in decisions. Ninety per cent of respondents said their overall experience at the practice was good or very good. Eighty two per cent of respondents said they would recommend the GP. We received 12 patient comment cards which indicated most patients were satisfied and happy with the service they received. They said staff were polite, helpful, kind and caring.

Are services responsive to people's needs?

The practice is rated good for providing responsive services.

The health needs of the patient population were known and the services were developed to meet them. The practice engaged with the local Clinical Commissioning Group (CCG) to address improvements required to healthcare in the local area. The Richmond Green Surgery was accessible to patients with mobility problems with room for wheelchairs and pushchairs. Arrangements were in place for patients to be seen in rooms downstairs when necessary. Staff had access to interpreters when required. The practice was open five days a week from 8.30am-2.00pm and 3.00pm-6.30pm and were closed on Thursday afternoons. When the practice was closed the answer machine directed patients to ring the out of hours service. A range of book in advance and urgent on the day appointments were provided. Patients were satisfied with the repeat prescription process. The practice manager was responsible for dealing with complaints. Records showed complaints were responded to and learning points were shared with staff. Patients were made aware of how to make a complaint by notices displayed in the waiting area and on the practice website. A Patient Participation Group was in place. This group met twice each year and were involved in seeking patient's views on the services provided. Improvements were made to the waiting area following the last practice survey. Patients made positive comments about getting urgent on the day appointments and said the referral process and repeat prescription service worked for them.

Good



Are services well-led?

The practice was rated as good for being well led.

Staff described the vision for the practice to deliver high quality care and promote good outcomes for patients. Whilst this was not written, it was understood by all staff at the practice. Systems were in place to monitor and manage risk. There was a clear leadership structure, staff were happy to be working at the practice and said they received the support they required. There was a Patient Participation Group (PPG) although it was not reflective of the whole patient population. The group were involved in patient surveys and developing action plans to improve the patient experience. There

Good



Summary of findings

were regular staff meetings that were recorded, however clinical meetings were on an 'as required' basis and records were not kept. Governance arrangements were in place which included the required policies and procedures to govern activity.

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 good for the care of older people.

Twelve per cent of the practice patients were aged over 70. There was a named GP for all patients over 75. The practice provided a range of book in advance and on the day urgent appointments and GPs provided telephone consultations and home visits for patients who were not able to attend the practice. Care plans were developed with people receiving end of life care and details were shared with the out of hours provider to ensure they were updated to any changes. Seventy five per cent of patients over 65 received their flu vaccination in 2013 which was above the national average of 73%. The practice worked to improve this number last winter by sending reminder letters and telephoning patients to eligible patients.

Good



People with long term conditions

The practice is rated good for the care of patients with long term conditions.

All patients newly diagnosed with diabetes were referred to a local service that provided information, education and support regarding the impact on the individual and how to manage the condition themselves. The practice provided a range of urgent on the day and book in advance appointments. Longer appointments were provided when necessary. The practice worked with other health and social care providers to ensure patients with complex health needs received joined up care and treatment.

Good



Families, children and young people

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

The practice provided urgent on the day appointments and appointments outside of school hours. Systems were in place to identify children in disadvantaged circumstances including those who are at risk. Failure to attend appointments for immunisations were followed up. Baby and childhood immunisation rates for the practice were below the local average. We were unable to ascertain action taken to improve this. The practice was accessible for families with pushchairs. The nurse's room was accessed by a steep flight of stairs, although reception staff said the nurse would see children downstairs if required.

Good



Summary of findings

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 practice had a higher proportion of patients aged 25-70 than the national average. They provided extended opening hours and telephone consultations to meet the needs of working age people. Extended hours appointments were provided from 6.30-7.00pm two evenings a week. Clinical staff told us they offered a range of NHS health checks to this population group. Seventy three per cent of women had attended for a cervical smear test; this was below the national average of 83%.

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.

Clinical staff told us they provided services to all. The practice held a register of patients with a learning disability and the electronic recording system had a flag system to identify other vulnerable patients. All patients with a learning disability had an annual health check. Staff had access to interpreting services for patients who did not speak English. Staff described signs of abuse and were clear about the actions they needed to take to protect vulnerable adults.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated good for the care and treatment of patients experiencing poor mental health.

Data showed patients were routinely asked about their alcohol consumption and smoking status which was recorded. Care plans were developed with patients and the practice worked with multidisciplinary teams to ensure patients experiencing poor mental health received joined up care and were directed to other support services when required. Advanced care planning was in place for patients with dementia.

Good



Summary of findings

What people who use the service say

We spoke with seven patients during our visit and received 12 comment cards, completed by patients who visited the practice on the day we inspected.

Patients we spoke with made positive comments about the care and treatment they received. They said staff spoke with them appropriately and they felt their privacy and dignity was maintained. Patients said the doctors and nurse had enough time to listen to them and explained any treatment to them and they felt involved in decisions about their care and treatment. They said the waiting room and consultation rooms were clean. The patients we spoke with had not made a complaint and most were not clear about how to make a complaint but felt they would be able to find out.

Nine comment cards indicated patients were satisfied and happy with the service they received at the practice. They said that it was a good, friendly service; staff were

polite, helpful and kind. The GPs were described as sympathetic, kind and caring. They said they were usually able to get urgent appointments. Patients said the repeat prescription service was efficient and they were referred to specialists when required.

The results from the 2014 National GP survey involved 411 surveys being sent out, with 102 returned giving a 25% completion rate. Responses showed 82% of patients would recommend the practice to someone new to the area and 90% of respondents said their overall experience at the practice was good. Ninety two per cent of respondents said it was easy to get through on the telephone, which was above the CCG average of 80%. Sixty nine per cent were satisfied with the opening hours which was below the CCG average of 71%. Ninety per cent of respondents said the last time they wanted to see a GP they got an appointment.

Areas for improvement

Action the service **SHOULD** take to improve

Action the provider **SHOULD** take to improve:

- Ensure the systems in place to deal with high risk medicines as part of the repeat prescription service are clear and understood by locum GPs;
- Ensure all GPs complete regular updates in child protection with records available at the practice;
- Record multidisciplinary meetings and
- Improve information about complaints so all patients are aware of the process.

Dr Antoine Sayer

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC inspector, a second inspector and a GP specialist advisor.

Background to Dr Antoine Sayer

Dr Antoine Sayer operates from The Richmond Green Medical Centre in Richmond town centre and has a branch surgery in a specialist hospital in Putney. The majority of patients are aged between 25-70. The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostic and screening procedures, maternity and midwifery and treatment of disease, disorder or injury.

The practice provides primary medical services through a General Medical Services (GMS) contract. A GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice provides a range of services including maternity services, child and adult immunisations, family planning and contraception services to just over 2,000 patients in the Richmond, Sheen and Twickenham areas with a branch surgery in Putney. The practice is a member of the Richmond Clinical Commissioning Group (CCG). It comprises of one male GP, one longstanding male locum GP, a practice manager, a part time practice nurse (female), a part time healthcare assistant (male), a part time phlebotomist and three part time administrative and reception staff.

The practice is open from 8.30am-2.00pm Monday to Friday and 3.00pm-6.30pm Monday, Tuesday, Wednesday and

Friday with appointments available from 9.00am to 11.00am Monday to Friday and then from 5.00pm to 6.30pm on Monday, Tuesday, Wednesday and Friday with extended opening hours provided from 6.30-7.00pm Monday and Wednesday. The GP completed telephone consultations for patients. The practice have opted out of providing out-of-hours services to their own patients.

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.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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?

Detailed findings

- 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 11 March 2015. During our visit we spoke with seven patients including the chair of the Patient Participation Group and a range of staff including the GP and regular locum GP, the nurse, practice manager and three reception staff at The Richmond Green Medical Centre. We observed staff interactions with patients in the reception area. We looked at the provider's policies and records including, staff recruitment and training files, health and safety, building and equipment maintenance, infection control, complaints, significant events and clinical audits. We looked at how medicines were recorded and stored.

Are services safe?

Our findings

Safe track record

The practice used information to identify risks and improve quality in relation to patient safety. These included for example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. The practice manager was the nominated person who dealt with alerts. The practice intranet had a link that directed staff to the alerts they received. The practice manager actioned the alerts on receiving them and this included sending emails to the relevant staff. The practice manager showed us an example of an alert they had received, this was about the Rotavirus vaccine that was being re-called. On receiving the alert the practice manager checked their stock to check if they had any of the identified batch numbers.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice shared with us an example where dispensing errors had been made by the pharmacy and the practice had taken action to rectify this.

We reviewed the safety records, incident reports and minutes of meetings for the last 12 month period where these were discussed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the 12 months preceding our inspection and these were made available to us. However, whilst the practice had a system to record these incidents there was a lack of a robust system to ensure that learning from incidents was shared with all staff. The practice manager showed us records of minutes where discussions with all administrative staff had taken place but we were told that informal meetings were held with the senior GP to discuss incidents.

Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at practice meetings and felt encouraged to do so. All staff we spoke with told us that incidents were reported to the practice manager as soon as possible and a written account of the incident was recorded in the

incident record book. Examples of incidents that we noted included an incident where the phlebotomist had encountered difficulties obtaining a blood sample from a patient. The incident had been documented and learning outcomes identified including offering reassurances to the patient.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that some staff had received relevant role specific training on safeguarding. The GP had received Level 3 child protection training in April 2013 and was due to complete an update. The locum GP told us they had completed Level 2 and the practice nurse had received Level 2 child protection training and reception and administration staff had all received Level 1 training. After the inspection we were sent the locum GPs training certificate confirming they had completed child protection training to Level 3 in 2013, although they had not completed any updated training.

Staff knew who to report concerns of abuse too, though they had never needed too. Staff could not describe all the different forms of abuse but could recognise concerns when we discussed scenarios. All staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We noted that the contact details were easily accessible.

The practice had a whistle blowing policy termed, “interest disclosure policy” and was available to staff via the practice intranet.

A chaperone policy was in place and on display on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professionals during a medical examination or procedure). Chaperone training had been undertaken by nursing staff, including health care assistants and this was provided at the practice by the GP. All receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe

Are services safe?

the examination. All staff acting as chaperones had been Disclosure and Barring Service checked. Patients we spoke with had been offered a chaperone when attending for examinations.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of any potential failures. The policy was being followed by the practice staff, who were able to confirm the actions they would take to address any failures to maintain medicines at the right temperatures. We saw records that confirmed the fridge temperatures were checked and recorded. All recordings for the past six months were within the required range.

Systems were in place to check medicines were within their expiry date and suitable for use. A check list was available and the practice nurse used this to ensure all checks were accurate. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using current directives that had been produced in line with legal requirements and national guidance. We saw a copy of directives from the Clinical Commissioning Group (CCG) and evidence that nurses had received appropriate training to administer vaccines including the signing of a patient specific direction in the absence of a patient group directive. All vaccination batch numbers were recorded in the patient records to ensure that if an alert was raised on the vaccine they could easily identify patients who had been affected.

The practice had a protocol for repeat prescribing. The GP told us they reviewed and signed repeat prescriptions that were prepared by administrative staff; this included those for high risk medicines such as Methotrexate and Warfarin. This could present a risk when the GP was not at the practice. Arrangements for blank prescription forms were secure and they were handled in accordance with national guidance. Patients told us the repeat prescription process was convenient for them.

Cleanliness and infection control

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

The practice manager was the infection control lead and they had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training.

All staff received training about infection control specific to their role on induction and annually thereafter. We saw evidence that the lead had carried out audits annually for the last three years and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. However, the practice did not have spillage packs to deal with all types of bodily fluids.

The practice had undertaken an audit of waste disposal in September 2014. This audit had identified some areas of improvement that the practice had rectified such as having yellow clinical waste disposal bags and pedal bins in all clinical areas.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Clinical staff confirmed they were responsible for cleaning between patients and we saw sufficient supplies for them to do this.

The practice had a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice had carried out a check in the last 12 months.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was

Are services safe?

routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence that calibration of relevant equipment had been completed in March 2014.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. The practice had Disclosure and Barring Service (DBS) checks for all staff whose roles required them and were in the process of making a decision to apply for checks for all staff in the long run.

The practice used a regular locum GP. A pack had been designed to ensure that all locum staff had the necessary checks and induction.

We were told about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. This included booking staff for extra hours based on identified patient needs. The practice had recently employed a practice nurse who was working four to six hours once a week. The practice manager was satisfied that this was sufficient for their patients as the practice also benefited from having a part time health care assistant. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough personnel to maintain the smooth running of the practice, and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there

was an identified health and safety lead. Reception staff knew the patients who needed to see the nurse on the ground floor and informed the nurse so patients did not have to climb the steep stairs to the first floor.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.). All staff we asked knew the location of this equipment, and records confirmed these were checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, IT breakdown, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to such as the, contact details of a heating company to contact in the event of failure of the heating system. The practice had also partnered with a specialist hospital in Putney where they provided GP services to support each other in times of such event should there be the need. We spoke about the difficulties of patients traveling to Putney if the premises were not able to be used. The practice manager advised that they had previously partnered with a local practice and were in the process of establishing new local arrangements.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. Fire extinguishers were checked in January 2015.

Are services safe?

Risks associated with service and staffing changes (both planned and unplanned) were noted on the practice risk log and possible action identified beforehand.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP told us they accessed best practice updates and guidelines from the National Institute for Health and Care Excellence, information from local commissioners and read relevant journals and articles to remain up to date. The locum GP told us they received regular updates and information from local commissioners. They used local prescribing guidelines.

We saw no evidence of discrimination when making care and treatment decisions. Discussions with the GP identified that patients were referred on the basis of need and that age, gender and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff had key roles in monitoring and improving outcomes for patients which included data input and medicine and clinical reviews. The GP met with local practices to look at comparators, benchmarking across the CCG and repeat prescribing. There was a system to follow up patients who attended the accident and emergency department.

The practice had a system in place for clinical audit. We reviewed audits including one audit regarding medicines used to reduce cholesterol that was carried out between June and September 2014. This identified 10 patients needed a change in dose following changes to prescribing guidelines. The action plan indicated a repeat cholesterol check in two months and a further audit in six months, although these had not been carried out at the time of our visit so was not a completed audit. The GP, practice manager and receptionist were involved in a completed audit aiming to increase the uptake of the flu vaccine. The audits were conducted in November and December 2014 and January 2015. After the first two audits, eligible patients who had not had the vaccine were sent a reminder letter. After the last audit, reception staff telephoned patients. The audit identified telephoning patients had a bigger impact on patients attending to have the vaccine. Other audits we were shown were seen to be data collection and did not identify impact on patients.

The practice used the information collected for the Quality and Outcomes Framework (QOF), which is the voluntary

incentive scheme for GP practices across the UK, to monitor outcomes for patients. For example, 90% of patients with enduring mental health had a record of their alcohol consumption in the last year and 70% of patients with dementia had an annual review. The regular tests for patients with diabetes were above or in line with the national average. The rates of childhood immunisations showed 85% of babies aged 12 months received their 5 in 1 immunisation. For children aged two years this was 88% and 63% for the MMR. These figures were all below the CCG average. We were unable to ascertain any actions planned to improve childhood immunisation. Ninety six% of 5 year old received the pre-school booster which was above the CCG average of 72%.

Information regarding attendance at accident and emergency was received from the CCG and the GP followed up with individual patients.

Effective staffing

Practice staff included medical, nursing, administrative and managerial staff. We saw staff were up to date with mandatory training. Staff told us they had access to the training and support they needed to carry out their role. Systems were in place for administrative staff to have an annual appraisal. GPs were up to date with their appraisal and had been revalidated or were working towards their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice nurse was clear about the expectations of their duties and had received training to carry out cervical screening, immunisations, dressings and ear syringing. The nurse was new to the practice and had not been there long enough to have supervision or an appraisal.

Working with colleagues and other services

The practice worked with other services to provide joined up care for patients with complex health needs. Monthly meetings were held with other health and social care professionals to ensure the needs of patients experiencing poor mental health, those with complex needs and patients receiving end of life care were known and care and treatment needs remained appropriate. However minutes were not taken of these meetings.

Are services effective?

(for example, treatment is effective)

Blood test results, X-ray results, letters including hospital discharge summaries and urgent faxes were received electronically or scanned onto the system and flagged for the GP to be dealt with. All staff we spoke with were clear about their role in dealing with results and letters. The practice used handover summaries when required for patients receiving end of life care and those with complex medical conditions to ensure the out of hours service had up to date information.

All referrals were sent to the Richmond clinical assessment service (RCAS) (a referral management service that had been operating in the borough of Richmond since August 2010) for review, who then send the 'choose and book' details to the patient (this is a national electronic referral service which gives patients a choice of place, date and time of their first outpatient appointment in a hospital). The practice had developed a referral tracking spreadsheet, so urgent referrals could be checked.

Information sharing

The practice used an electronic recording system; all staff had received training in how to use the system. The practice used special patient notes for patients receiving end of life care to ensure the out of hours service had a clear understanding of the patients' needs and wishes. There was a system for the out-of-hours service to send records of patients seen to the practice first thing in the morning; these were checked by the GP daily to ensure any actions were completed.

Consent to care and treatment

Clinical staff we spoke with were aware of their responsibility to seek consent before providing treatment. They said they requested verbal consent for examinations and demonstrated their understanding of when best interest decisions were required and the Mental Capacity

Act 2005 and Gillick competence (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). Suitable arrangements were in place for seeking parental consent prior to childhood immunisations.

Patients with dementia and learning disability were supported to make decisions through the use of care plans which they were involved in developing and reviewing.

Health promotion and prevention

Clinical staff told us they spoke with patients about how to maintain good health and for patients with long term conditions including diabetes they spoke about the importance of lifestyle on their condition.

The practice had a system for new patients to be seen by the nurse or the health care assistant to seek information about the individual's and family health concerns. Any identified issues were referred to the GP. New patients aged 15-24 were offered Chlamydia and Gonorrhoea testing. There was a range of information leaflets available to patients in the waiting area.

The electronic recording system identified patients who required additional support, including patients with dementia, learning disability and those receiving end of life care.

Seventy five per cent of patients over the age of 65, 69% of those at risk and 95% of patients with diabetes had the flu vaccination in 2013. These figures were above the national average. Data showed the number of childhood immunisations was just below the local average. Dementia screening was offered to eligible patients over 60 years of age. The practice performance for cervical smear uptake was 73%, below the national average of 82% although in line with the CCG average of 71%.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey. Eighty five per cent of respondents said they found receptionists helpful. Ninety per cent of respondents said their overall experience at the practice was good or very good. Eighty two per cent of respondents said they would recommend the GP which is slightly above the national average of 79%.

We received 12 comment cards from patients who attended the practice on the day we visited. Most of the cards contained positive comments and patients said they received a friendly and good service. They said that staff were polite, helpful, kind and the GPs were sympathetic, kind caring and listened.

Patients we spoke with said staff were respectful and spoke with them appropriately. They said their privacy was maintained during appointments because there were two doors between the waiting area and the consultation room. However one patient felt that sometimes conversations in other consulting rooms could be overhead due to the nature of the building.

We saw staff spoke politely to patients and greeted many by their name. The reception and waiting area were open and conversations could be heard. The reception desk was low and open so patients and visitors could see documents on the desk. Patients said they had been offered a chaperone when they were to be examined by one of the GPs.

Records were stored securely. Consultations took place in rooms with the door closed. Curtains were provided in the two consultation rooms to provide privacy during examinations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with said they were involved in making decisions about their care and treatment. According to the National GP survey 92% of respondents said that the last GP they saw or spoke to was good at involving them in decisions with the national average at 81%.

Staff at the practice spoke five languages and told us they had access to face to face and telephone interpreting services when required. The GP said patients had bought a relative to interpret on occasions and they assessed whether this was appropriate.

There was a range of information leaflets about different long term health conditions and maintaining a healthy lifestyle in the waiting area for patients to read and take away.

Patient/carer support to cope emotionally with care and treatment

Patients and carers had access to a range of leaflets in the waiting area relating to support services available in the local area to meet their various needs. Patients we spoke with confirmed that they would know where to find support if required and said that staff were caring and provided emotional support, or advised them of how they could access emotional support when required. Comment cards received from patients reflected what patients had told us.

Information about what to do in the event of bereavement was provided on the practice website. The GPs told us they knew who carers were and would contact relatives or carers after a bereavement.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the local population were known and understood and the practice was responsive to those needs. However, patients could only access female clinical staff four hours each week. Patients we spoke with did not raise this as an issue and this had not been identified in complaints received in the last 12 months. The practice offered a range of book in advance and on the day urgent appointments. Clinical staff attended training updates to ensure they were aware of the most up to date treatments.

A Patient Participation Group (PPG) was set up three years ago and met twice a year. The group were not fully reflective of the younger patient population group. The PPG were involved in developing and analysing a practice patient survey and developing an action plan to make improvements. We were told improvements made included increasing the range of reading material available in the waiting area and the provision for blood tests to be carried out at the surgery. Most patients we spoke with were not aware of the PPG and had not been asked to complete a survey to feedback on their experience of the practice.

Tackling inequity and promoting equality

The practice recognised the needs of the different groups who used the service and made changes by providing extended opening hours and improving the reading material in the waiting area to accommodate these. The reception and waiting area at The Richmond Green Surgery were large enough to accommodate patients with wheelchairs and prams and allowed access to the treatment and consultation rooms on the ground floor. Reception staff said they knew patients who needed to see the nurse on the ground floor and indicated this on the appointment for the nurse. The nurse confirmed the system in operation identified when she needed to see patients on the ground floor.

Staff told us they could speak five languages between them and could access face to face or telephone interpreters to speak with patients whose first language was not English. The GPs carried out home visits when required.

The electronic recording system had an indicator to show staff if a patient was vulnerable and if a child was subject to a child protection plan. Reception staff knew the types of appointments that needed longer time slots and were clear about prioritising appointments for children.

Access to the service

The practice was open five days a week from 8.30am to 2.00pm and 3pm-6.30pm Monday, Tuesday, Wednesday and Friday with extended hours provided on Monday and Wednesday from 6.30-7.00pm. When the practice was closed, the answer machine message directed patients to contact the out of hours provider. There were a range of book in advance and appointments provided for on the day emergencies including appointments outside of school hours. The GPs carried out telephone consultations. Home visits were carried out when required. Longer appointments were made available for patients when required. Reception staff were clear about the procedures that required a longer appointment. Appointments were bookable in person or on the telephone.

Patients we spoke with were satisfied with the appointment system and confirmed they could see a GP on the same day when they needed to.

Listening and learning from concerns and complaints

The practice had a suitable system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for dealing with complaints. These were discussed at staff meetings.

We looked at the four complaints received in the last 12 months and found they were responded to in a timely manner. Where patients were not satisfied with the outcome, they were referred to the ombudsman. Learning from complaints was shared with staff at meetings. Records were kept of compliments received and these were shared with staff, examples of this was a number of thank you letters received thanking clinical staff for the extra information and support provided.

The complaints procedure was displayed in the waiting room for patients. Not all patients we spoke with were aware of how to make a complaint, although most would speak with reception staff or the practice manager or look up how to on the internet.

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 staff all told us they had a vision to deliver high quality care and promote good outcomes for patients. All staff were able to clearly articulate this and knew what their responsibilities were in relation to these. However the practice did not have a written vision.

The principal GP was responsible for all clinical issues and practice manager was responsible for all administrative issues. The practice manager advised that the appraisal process was linked to delivering good quality care and we saw this evidenced in the records we viewed. All staff were aware of their contribution to continually offer a good service.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity such as recruitment policies and these were available to staff via the desktop on any computer within the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. For the period 2013/2014 the practice had achieved (97.5%) 877.38 points out of 900. We found that a meeting was held at the start of the winter to discuss how uptake for flu immunisations would be increased and this involved clinical and non-clinical staff. Administration staff had been trained to place reminders on patient notes to encourage them to book outstanding appointments such as reviews. The practice had completed one audit cycle. Information provided to us demonstrated the practice carried out a number of data collection activities such as medicines monitoring and patient alcohol consumption.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as fire risk, safety risk and vaccines and medicines risks. A system was in place for scoring and evaluating these risks. We saw that the risk log was updated annually or after an event had occurred.

Leadership, openness and transparency

The practice had a leadership structure which had the GP as the clinical lead and practice manager the lead for all administrative duties. We spoke with four members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to at the practice with any concerns.

We saw from minutes that team meetings were held every two months for the last five months leading to our inspection. Both staff and the practice manager confirmed having weekly informal meetings. However none of these meetings were recorded. 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 or ad-hoc with the manager who was easily accessible. Staff felt that their views were listened to.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, training, and the management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, these included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

We were told the practice had an active Patient Participation Group (PPG). However some patients reported not knowing about the existence of the PPG. We met a member of the PPG during our inspection. The PPG contained only the retired and no members represented ethnic minorities. The PPG had carried out a survey in July 2014 and the practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had also recently introduced the Family Test and Friends Test from December 2014. The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

The practice had gathered feedback from staff generally through informal staff meetings and appraisals. All staff we

Are services well-led?

Good 

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

spoke with said the practice had an open environment and they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the practice manager. Staff told us that an “open door” policy was encouraged at the practice. As such they had the opportunity to give their feedback at any time.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their development through training We looked at four staff files and saw that regular appraisals took place which included a personal development plan. We observed that the practice had recently recruited a new practice nurse. Training needs had been identified and records confirmed that this was due to take place.