Dr Christopher Anthony Grainger Stern

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.

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Overall summary

Dr Christopher Anthony Grainger Stern, also known as Carepoint Practice, provides primary medical services for patients in the Hillingdon and Uxbridge area.

We carried out an announced inspection of the service on 1 September 2014. We found the practice was safe, effective, caring, responsive and well led in many areas that we inspected. However we also found there were areas that needed improvements.

The way patient's paper based records were stored was not safe or secure and could be accessed by unauthorised members of staff.

The practice was providing a high number of telephone consultations to meet patient demand for access. Patients had given mixed views about this service. There was no audit planned or completed to evaluate the treatment and diagnosis given during telephone consultations to understand how effective this was and what improvements could be made.

The practice had comprehensive safeguarding policies and procedures in place to protect vulnerable patients. There were systems in place to manage health and safety checks regularly. Staff were trained appropriately and received support from the management team as required.

Patients gave mixed views about their experiences with the practice and the evidence we looked at showed both positive and negative comments.

The practice had a system in place for handling complaints and concerns, however this needed improvements. Patients were referred to speak to the practice manager to make a formal complaint. However, complaint forms were not available in the waiting area and there was no information on where to get help completing a complaint for patients that may be vulnerable or where English was not their spoken language.

We found that the practice was not meeting two regulations required to ensure that standards of quality and safety were maintained. This was in relation to managing complaints and storing records. We have asked the practice to send us a report, setting out the action they will take to meet these safety standards. We will check to make sure that action is taken.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Many areas of the service that we inspected were safe but some areas required improvement. Although the staff carried out regular checks of the premises we noted that the way patient's paper based records were stored was not safe or secure and could be accessed by unauthorised members of staff.

We saw that health and safety risk assessments regarding the environment had been completed and actions taken to minimise risks to staff and patients, however the inadequate storage of records was not risk assessed.

We saw an infection control audit that had been completed by a practice nurse and the practice manager in December 2013 and this was regularly reviewed and updated with actions.

The practice had safe systems in place to record and investigate incidents where there were potential issues regarding safety. There were lessons learnt from incidents to prevent reoccurrences. There were comprehensive safeguarding policies and procedures in place to protect vulnerable patients. Staff were trained and aware of how to manage any suspected abuse. We saw the practice had a chaperone policy in place and a poster displayed in the waiting area for patients to read. Patients were made aware of this facility being available to them. We found that staff were appropriately vetted before they started work at the practice to ensure treatment and care was delivered to patients safely.

Are services effective?

The practice was not effective in the way they evaluated clinical improvements for care and treatment provided to patients. There was no audit planned or completed to evaluate the treatment and diagnosis given during telephone consultations to understand how effective this was and what improvements could be made. We saw evidence of clinical audits that related to prescribing medicines but no other audits were completed or planned. The GPs had only completed clinical audits as recommended by the CCG pharmacist advisor.

The practice was effective in the way they delivered care and treatment for patients. They had a system for staff to follow national and local clinical guidelines when treating patients. Staff were appropriately trained and inducted prior to starting work in the practice. There was a range of health promotion information in the waiting area and on the website for patients to read.

Summary of findings

Are services caring?

There were mixed views from patients about the care they received from the practice. Some patients told us they felt they were treated with dignity and respect and given time to explain their problems to the GP. They told us staff were friendly and helpful. Other patients told us they felt rushed by the GP they spoke with and did not feel they received the care and attention they would have liked. Some patients felt unconfident about receiving treatment and diagnosis on the telephone without being seen. Most patients told us they were involved in their decision for treatment and had given their consent verbally.

We looked at the results of the 2014 national GP survey that collected the views of 118 patients who used the practice. We saw 66% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. This was below the regional average which was 76%. The majority of the patients complemented the practice nurses about their caring and accommodating services. The same survey results showed the practice nurses were caring.

Are services responsive to people's needs?

The practice provided patients with same day access to speak to a GP or nurse practitioner. A national survey reported the practice to be above average in providing access to patients. Patients were offered telephone consultations or face to face consultations.

The practice had a system in place for handling complaints and concerns, however this needed improvements. Patients were referred to speak to the practice manager to make a formal complaint. Complaint forms were not available in the waiting area. There was no information on where to get help completing a complaint for patients that may be vulnerable or where English was not their spoken language.

The practice engaged a Patient Participation Group (PPG) to discuss views on how to improve services for the patients.

Are services well-led?

Both clinical and administrative staff described the culture within the service as being open and supportive. Staff told us they felt the management team valued them all individually for their role within the practice and they were all encouraged to fulfil their potential with support of the management.

The practice had not completed or planned audit cycles to evaluate clinical improvements for the treatment and care provided to patients. They were unable to evidence base any risk or make improvements.

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
To help manage the demand for elderly patients to see a GP the practice provided same day telephone consultations for patients. There was also the option to arrange a face to face consultation or a home visit if the patient had mobility problems.

The practice also had arrangements to see elderly people as needed in three local care homes. One of the managers for the care homes that we spoke with told us they had no concerns and thought the telephone consultations worked well as the carers could help their residents sooner than having to wait for the GP to visit.

People with long-term conditions
The practice told us there were systems in place to follow up reviews for patients with long term conditions. There was a system in place that would generate follow up letters for patients to remind them to contact the practice for a review that was due.

Mothers, babies, children and young people
The practice provided antenatal care and postnatal care for mothers. There were nurse-led baby clinics for mothers and young children that were generally for vaccinations but also for providing healthcare information and baby care. The practice also ran nurse led clinics for women's health that provided smear tests, contraceptive advice and information about sexual health.

The working-age population and those recently retired
The practices opening hours enabled patients who were working to get an appointment when they needed one. Patients could book appointments online once they registered for login details. The practice provided telephone consultations for patients that could not attend the practice however this received mixed views from patients.

People in vulnerable circumstances who may have poor access to primary care
The practice told us they knew who the patients were registered with learning disabilities and that there were not many. They offered support and worked jointly with social services to help the patients.

People experiencing poor mental health
Patients were referred by the GPs to secondary care if they were experiencing mental health difficulties. When patients had

completed their treatment in secondary care they were discharged back to the GP practice for continued treatment. GP's reviewed patients and prescribed medications as needed and if further support was requested the GPs advised accordingly.	

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection. We found there were mixed views from patients about the care they received from the practice. Four out of the seven patients we spoke with told us they felt they were treated with dignity and respect and given time to explain their problems to the GP. These patients told us the reception staff were helpful and friendly and they had no complaints.

Other patients told us they felt rushed by the GP they spoke with and did not feel they received the care and attention they would have liked. Some patients felt unconfident about receiving treatment and diagnosis on the telephone without being seen.

We also spoke to an elderly couple who told us they liked the telephone consultation system because they found it difficult to go to the practice. They told us their GP knew all their health problems well and was confident with the advice they received over the telephone.

One of the managers for the care homes that we spoke with told us they had no concerns and thought the telephone consultations worked well as the carers could help their residents sooner than having to wait for the GP to visit.

Six of the seven patients we spoke with told us they were involved in their decision for treatment and had given their consent verbally by agreeing to take the GP or practice nurse's advice. One patient told us that although they were very happy with the service they had received from the practice, their GP had someone else in the room in their last consultation and had not informed them about who the person was or asked for their consent. They told us this was the first time this had happened and usually they are introduced and asked for consent.

The majority of patients we spoke with told us they were not able to see the same GP at each appointment when they had wanted to. One patient with long term problems told us they had not always been able to see a GP of their choice and felt this prevented a consistent approach to their care. They told us the reception staff would not give them an option most of the time and if they asked to see a particular GP they were told there were no available appointments.

We had sent comment cards to the practice for patients to complete as they attended the practice two weeks in advance of our visit. We found on our arrival that there were no completed cards.

We reviewed some of the comments that were made through the NHS Choices website and saw some positive comments about reception staff, practice nurses, GP's and the care they received without delays. There were comments about staff being kind and caring and understanding.

Areas for improvement

Action the service MUST take to improve

- Patients' paper based records must be stored securely.
- The complaints procedure needs to be made more accessible to patients and findings should be shared with staff to encourage learning and improvement.

Action the service SHOULD take to improve

- Advertise interpretation services available to patients.
- GP must refresh cardiopulmonary resuscitation (CPR) training.
- Clinical audits should be completed to assess and evaluate the effectiveness of treatment and care given to patients.

Dr Christopher Anthony Grainger Stern

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist adviser. The team included a practice manager, specialist advisor and an expert by experience. They are granted the same authority to enter registered person' premises as the CQC inspectors. Experts by experience are people who use services or care for people who use services. They assist us in gaining the perceptions of patients during our inspections.

Background to Dr Christopher Anthony Grainger Stern

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures, treatment of disease, disorder or injury. The practice has approximately 5,000 patients registered. There are a higher number of elderly patients and a lower number of under 18 year olds registered with the practice compared to practices nationally and locally.

The practice lead is a senior GP that has worked in the practice for over 20 years. There are two other GPs one works fulltime and the other works one day a week. The two full-time GPs are male and the part-time GP is female. In addition there are two practice nurses, one nurse practitioner and one recently recruited health care assistant.

The non-clinical team consists of the practice manager, the secretary and a team of receptionists.

The practice is part of the extended hours scheme and the opening hours are:

Monday 08:30 - 18:30

Tuesday 07:30 - 18:30 (Extended hours)

Wednesday 07:30 – 18.30 (Extended hours)

Thursday 07:30 - 16:30 (Extended hours)

Friday 07:00 - 18:30 (Extended hours)

The practice does not provide out-of-hours services for patients. Outside of normal practice hours patients are directed to an out-of-hours service or the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we held on our Intelligent Monitoring system. We met with NHS England and the local Clinical Commissioning Group (CCG) for Hillingdon. They did not highlight any particular areas of concern at this practice.

We carried out an announced inspection on 1 September 2014 between 9:00am and 5:30pm. During our visit we spoke with a range of staff that included GPs, nurses, receptionists and administrators. We also spoke to seven patients and one representative from the Patient Participation Group (PPG). We looked around the premises, reviewed storage of patient's records and looked at a range of evidence relating to staff training, recruitment and health and safety in the practice.

Are services safe?

Our findings

Safe Track Record

We found incidents which potentially impacted on patient and staff safety were recorded, investigated and responded to by the practice to reduce the risk of them reoccurring. The practice manager showed us the accident and incident book that they used for recording any incidents. We saw there had been clear records of when the incident had occurred, who was involved, details of the incident and the remedial action taken. For example, we saw an incident record that involved staff hurting themselves due to items being in the way of access. There was a record of the practice actions which included clearing any clutter and obstructions and briefing all staff about safety. The practice manager told us they were the accountable officer for reporting accidents and incidents. Staff told us if they encountered any trips or falls they would report this to the practice manager as soon as possible.

Staff told us medical safety alerts were received and shared with the team when they were received and action taken where appropriate. The practice manager gave us an example where risks were identified and immediate action taken.

Learning and improvement from safety incidents

The practice recorded incidents, complaints and reviews of care where there were potential issues regarding safety. There were significant event forms that were completed with details of the incident and what the risks were to patients. Meetings were held to discuss the outcomes and any learning from significant event reviews and the meetings included any staff that the learning was relevant to. We saw minutes from meetings where cases were discussed. We were shown examples of two cases; one case was to do with a prescription error and another to do with a fax going to the wrong number. In both cases there was some documented evidence of lessons being learnt and safety checks being put in place to avoid similar events reoccurring. We noted that significant events had also been reported to the Care Quality Commission (CQC) as required.

Reliable safety systems and processes including safeguarding

The practice had safeguarding policies and procedures in place to protect vulnerable patients. The policies gave information and guidance to staff to look out for possible signs of abuse, neglect or harm. All staff had received training in child protection in the last 12 months. Records showed that all clinical staff had received Level 3 training and non-clinical staff had received Level 1 training in child protection. Staff had received the appropriate level of child protection training for their role.

Although a safeguarding lead had not been formally appointed staff told us that they would raise a safeguarding concern either with the lead GP or with the practice manager. They were able to tell us what they would do if they suspected abuse and showed us the contact numbers reporting a concern.

The practice had a whistleblowing policy. Whistleblowing is when a worker reports suspected wrong doing at work, if they had any reason to. This could be for example, if anyone at work was neglecting their duties. The staff we spoke with told us they would not hesitate to report poor practice or concerns.

We saw the practice had a chaperone policy in place and a poster displayed in the waiting area for patients to read. There was information also available on the practices' website. Patients were advised to speak to the GP or someone at the reception desk if they wanted a chaperone present during their consultation. Records showed that eight members of staff had received training to be a chaperone for patients. All these members of staff also had Disclosure and Barring Service (DBS) checks to ensure they were suitable to work with vulnerable adults and children.

Monitoring Safety & Responding to Risk

We saw that health and safety risk assessments regarding the environment had been completed and actions taken to minimise risks to both patients and staff. Although the staff carried out regular checks of the premises we noted that the way patient's paper based records were stored was not safe or secure and could be accessed by unauthorised members of staff. The records were filed in open shelves behind the reception desk. The area was shared with two other GP practices and each practice had its own filling shelves that were colour coded. However, staff that did not work at Carepoint Practice had access to the records. When we spoke to the practice manager and the practice they told us they had identified this issue but they had not been able to resolve the problem because the building and

reception area was a shared cost and responsibility between themselves and two other practices. We saw no risk assessments completed for the way the records were stored.

Clinical staff had recently received annual training in basic life support and cardiopulmonary resuscitation (CPR); however we noted that one of the GPs had not revisited CPR training recently and was six months out of date. The GP told us they will schedule a training session. The GP told us the practice always had another GP and practice nurse available to assist if a life threatening situation was to occur in the practice.

We looked at the medical emergency kit and saw all the medicines were in date and correctly stored. There was an oxygen cylinder and defibrillator that was checked, dated and ready for use if needed in an emergency. The practice nurse and health care assistant were responsible for carrying out these regular checks as part of the medication audits and we noted the last date checked was 19 August 2014.

We saw that staffing levels were set based on the number of patients registered with the practice and varied depending on demand throughout the week. There were two GPs available throughout the weekdays and a combination of practice nurses, a health care assistant and a nurse practitioner.

These levels of staff were seen during our inspection. This showed the staffing levels and skill-mix was sustained at all hours the practice was available.

The patients benefited from a stable staff team because staff retention was high. This was supported by staff we spoke with who told us the practice had good staffing levels. The practice did not use locum GPs as they preferred to manage within the team for consistency. The practice had support from neighbouring practices, who had offered to help when required. Staffing levels were frequently reviewed by the practice manager, to ensure they had enough staff members with appropriate skills.

Medicines Management

Vaccines were stored appropriately in two dedicated vaccine fridges. These fridges were subject to daily temperature checks to ensure the vaccines were stored between the correct temperatures of two and eight degrees Celsius. This was supported by the fridge temperature logs made available to us. We found all medicines and stored vaccines were within expiry date. Medicines management policies were in place and staff were familiar with these.

The practice manager told us prescription pads were stored safely and securely. When boxes of prescriptions were delivered they were signed for and taken to secure storage immediately. All prescriptions were signed by the GP before they were issued to the patient. Patients were able to request repeat prescriptions by sending an email to a secure 'NHS' account or by fax. There was a system in place for reviewing repeat prescriptions and we were told that patients who failed to attend for their prescription review were followed up and reminded to attend their review.

Cleanliness & Infection Control

The practice had a hygiene and infection control policy that had been reviewed in April 2014. The policy had a statement explaining the practice's responsibilities in maintaining infection control for the safety of staff and patients and listed responsible staff for clinical and non-clinical areas of infection control. There was a responsible GP for any clinical issues and the practice manager was responsible for any non-clinical issues.

The practice completed regular checks to identify any issues that may be unsafe and these were rectified and logged appropriately. We saw an infection control audit that had been completed by a practice nurse and the practice manager in December 2013 and this was regularly reviewed and updated with actions. The practice manager provided us with a copy and we noted that it had been completed in December 2013 and reviewed in January 2014, February 2014 and April 2014.

We saw evidence from the audit that the practice identified areas where improvements were required and actions noted and completed. For example the practice identified cracks in the ceilings and the walls in some of the consulting rooms during the audit of December 2013. We saw actions had been logged and completed to rectify the problem by February 2014.

We found treatment and consultation rooms were clean and hygienic. The practice manager told us a member of staff completed a weekly cleaning audit to check the practice was being cleaned appropriately. The building maintenance team were responsible for providing cleaning

services. They told us there was regular communication with the cleaners to report any issues with cleaning. Equipment and materials for cleaning were colour coded to ensure it was used in designated areas of the practice such as clinical rooms and toilets.. The maintenance team told us clinical waste was stored and disposed of in line with guidance from the Department of Health.

The practice provided us with a copy of the Legionella risk assessment that was completed for the building in July 2012. There were some improvements required and actions were listed for the building maintenance team. The assessment was completed by a specialist company that will revisit the practice to see what improvements have been made.

Staffing & Recruitment

The practice had a recruitment policy which ensured a consistent process was followed when staff were employed. We reviewed four staff records and saw information was requested for new staff including references where staff had worked previously and full employment histories. Staff had criminal record checks undertaken using the Disclosure and Barring Service (DBS). We saw evidence of photographic identification and proof of professional registrations and qualifications on file.

New staff completed an induction prior to starting work. One person we spoke to who had been recruited recently told us they received a full induction that involved reading the practices policies and procedures and being asked some questions to test their knowledge at the end. The practice manager informed us that induction periods were for two weeks and included training on the medical software system and drafting letters with medical terminologies.

Dealing with Emergencies

The practice had a detailed 'business continuity plan' that covered what to do in the event of a serious incident like a fire or flood at the premises that could have an impact on services being available. The practice had 'buddy' arrangements with two local practices and the practice manager, the secretary and the practice have hard copies of the plan offsite in their homes. We saw there was clear guidance and contact details for staff to call various departments and get support in continuing the services for patients.

Equipment

There were good systems in place to ensure that the checks were made at the required intervals on the fire alarm system, fire extinguishers and portable electrical appliances in the practice.

There were records of regular checks that had been completed for the fire alarm system, fire extinguishers, oxygen cylinder and portable electrical appliances.

We saw contracts were in place for the calibration of clinical equipment including blood pressure monitors, thermometers, fridges, weighing scales, nebulisers and oximeters. The last check was completed in April 2014.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice had a GP lead for clinical updates who was responsible for ensuring care and treatment was delivered in line with evidence-based guidelines, such as those from the National Institute for Health and Care Excellence (NICE). The GP demonstrated how staff could access a shared system that held up to date clinical guidance and how updates were made and cascaded. One member of clinical staff told us they referred to this system regularly to ensure they were providing up to date care to diabetic patients, for example.

Staff told us any changes to guidance would be communicated to them and where applicable changes were made to care protocols. They told us any clinicians who attended external training, where they learnt new or different approaches to care, shared this with the clinical team.

Management, monitoring and improving outcomes for people

The practice used the national Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management of GPs in the National Health Service. Through this scheme the practice is rewarded for how well they care for patients. Some examples of the areas of care assessed are smoking, diabetes, mental health, chronic obstructive pulmonary disease (COPD), stroke and asthma. In the recent 2012/13 QOF results the practice had achieved 100% in all the areas of care that were assessed apart from smoking where they had achieved 97%. The practice manager told us that this was due to a small number of patients that did not re-attend the practice to complete their smoking cessation assessments. The practice have since recruited a lead health care assistant that received training in smoking cessation to improve the outcomes for patients that want to quit smoking.

We saw evidence of the clinical audit that had been undertaken by the practice and improvements made as a result. However, these were all to do with medicines being prescribed by clinicians. The GPs had only completed clinical audits as recommended by the CCG pharmacist advisor. When we spoke to the lead GP for audits they told us they had yet to plan for further audits to complete and accepted they could do more. We were informed by the practice that in an average week the practice did approximately 170 telephone consultations for registered patients. There was no evaluation or survey done for telephone consultations to evidence the effectiveness of the service and understand what improvements could be made.

Effective Staffing, equipment and facilities

All new staff were provided with training, relevant to their role. The practice had recently recruited a Health Care Assistant (HCA). They told us they had received additional training before starting work at the practice in providing immunisation vaccines, smoking cessation clinics and diabetic foot checks. They completed an induction programme that involved shadowing experienced clinical staff and administrative competency tests set by the practice manager. For example they were asked to draft a letter on the computer for a patient that involved clinical terminologies.

We saw from the recent staff training plan that staff had received the necessary and relevant training. This was for example in safeguarding children and adults, chaperoning, fire safety, infection control and CPR. We noted that one GP was six months out of date with their CPR training requirements. The GP was able to explain how they would manage any risks until they completed their training.

Two out of the three GPs had received their appraisals and no issues of concern were raised. They are currently awaiting revalidation in 2015. Revalidation is the process by which doctors demonstrate they are up to date and fit to practise. Staff said the practice was supportive and assisted their professional development. They told us they received an annual appraisal that worked well to identify any training needs. For example, one member of staff who had an appraisal in July 2014 told us they were receiving one to one training from the practice manager to develop their administrative skills.

All the equipment and facilities in the practice were regularly checked and records were logged of any actions for improvements required and completed.

Working with other services

The practice held regular multi-disciplinary team meetings with external health care professionals. Palliative care

Are services effective?

(for example, treatment is effective)

nurses, district nurses and CCG pharmacists attended different multi-disciplinary meetings. We saw from meeting minutes that staff discussed patient care and any issues which might affect patients' safety and welfare. For example we saw there had been discussions relating to district nurses receiving admin support so there was more time available for them to support patients. We saw another example where a CCG pharmacist had discussed prescribing advice for dermatology issues. The service invited external professionals to clinical team meetings to provide training and share their expertise. The CCG pharmacist advised the practice about prescribing audits.

There were alerts set up against patient's electronic records where regular tests and follow ups were required if for example patients had long term conditions. Clinical staff and administrative staff were prompted to remind patients about any tests that may be due and to initiate a review if this was appropriate. There was a system in place that would generate recall letters for patients that may have forgotten about follow up tests or a review that was due.

Health Promotion & Prevention

There was a range of literature accessible in the practice waiting room and on the practice website aimed at patients for health promotion and self-care. We observed in the waiting room booklets and leaflets on topics such as diabetes, dementia awareness, heart disease and stroke for patients to read and take away with them.

The practice booklet for patients and the website had information about healthy eating, avoiding stress, stopping smoking and keeping alcohol intake low. On the website there was up to date information for new mothers on child vaccines and signposting for women's health.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We found there were mixed views from patients about the care they received from the practice. Four out of the seven patients told us they felt they were treated with dignity and respect and given time to explain their problems to the GP. These patients told us the reception staff were helpful and friendly and they had no complaints. One patient who was a mother told us the GP explained any treatment or medications required and felt happy with the information that she received from the practice.

Other patients told us they felt rushed by the GP they spoke with and did not feel they received the care and attention they would have liked. Some patients felt unconfident about receiving treatment and diagnosis on the telephone without being seen.

We reviewed some of the comments that were made through the NHS Choices website and saw some positive comments about reception staff, practice nurses, GP's and the care they received without delays. There were comments about staff being kind and caring and understanding.

We also spoke to an elderly couple who told us they liked the telephone consultation system because they found it difficult to go to the practice. They told us their GP knew all their health problems well and was confident with the advice they received over the telephone.

One of the managers for the care homes that we spoke with told us they had no concerns and thought the telephone consultations worked well as the carers could help their residents sooner than having to wait for the GP to visit.

However, some patients had made negative comments. We reviewed comments on the NHS choices website and noted that patients had felt the reception staff had been rude to them and they hadn't received the care and attention they felt they needed from the practice team. There were comments about patients being unsatisfied with the telephone consultation service. One person commented that the system was 'robotic' and reception staff were inward facing.

We also looked at the results of the 2014 national GP survey that collected the views of 118 patients who used the practice. We saw 66% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. This was below the regional average which was 76%. The regional average is calculated from the same patient survey results of other local GP practices in Hillingdon CCG area. The majority of the patients complemented the practice nurses about their caring and accommodating services. The same survey results showed the practice nurses were caring. 88% of respondents said the last nurse they saw or spoke to was good at giving them enough time and 91% of respondents had confidence and trust in the last nurse they saw or spoke to.

We noted that there was a female GP working at the practice but this was for one day a week. We had comments from one patient referring to this and saying that they could never get an appointment to see the female GP because she was always booked up. A member of staff also commented that there were not enough appointments available with the female GP and therefore offered appointments with the nurse practitioner.

Involvement in decisions and consent

The results of the national GP patient survey published in July 2014 showed that out of 118 responses, 52% stated the last GP they saw or spoke to was good at involving them in decisions about their care. This was below the regional average which was 69%. Further results showed 65% of respondents stated the last GP they saw or spoke to was good at explaining tests and treatments. This was also below the regional average which was 77%.

From the patients we spoke with six out of the seven told us they were involved in their decision for treatment and had given their consent verbally by agreeing to take the GP or practice nurse's advice. One patient told us that although they were very happy with the service they had received from the practice, their GP had someone else in the room in their last consultation and had not informed them about who the person was or asked for their consent. They told us this was the first time this had happened and usually they are introduced and asked for their consent.

The majority of patients we spoke with told us they were not able to see the same GP at each appointment. One patient with long term conditions told us they had not always been able to see a GP of their choice and felt this

Are services caring?

prevented a consistent approach to their care. They told us the reception staff would not give them an option most of the time and if they asked to see a particular GP they were told there were no available appointments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice responded to patients' needs as required. There were urgent referral systems in place for any suspected cancer cases and these were followed up with the secondary provider to ensure the patient had an appointment booked within two weeks. The practice used 'choose and book' for non urgent referrals. This is a system where GPs can book an NHS appointment directly if it is available with the secondary provider.

The practice provided home visits for patients that had problems with mobility. One of the GPs told us they provided home visits to patients who lived locally in three care homes. We spoke with the manager for one of the care homes to ask them about the service they received from the practice. They told us they were able to speak to a GP or a nurse within a reasonable time to have a telephone consultation. If the clinician felt they needed to see the patient they would visit them at the home. The manager told us they usually had the same GP or nurse coming to the home so this was good for the patients to see familiar faces.

The practice had access to a telephone interpretation service, if patients required it. This was however, not seen to be advertised widely. There was no information about this in the practice booklet for patients. The nurse told us she had used it once for a patient. Staff told us that patients who do not speak English usually bring a friend or relative with them to translate.

We saw access to the practice was suitable for patients with mobility difficulties and mothers with children in prams. All the treatment and consultations rooms were on the ground floor.

Access to the service

The practice provided patients with same day access to see or speak to a GP or nurse practitioner. The GP national survey from 2014 received 118 responses and found 92% of patients said the last appointment they got was convenient. This was a higher proportion than the local and national average. This included patients that received a telephone consultation.

The practice told us they had a policy where all patients had the option to request a face to face appointment if they preferred but this would often mean waiting to see a GP and the preferred GP may not be available. GPs told us the telephone consultation was available on a priority basis depending on how serious the problem was. Patients were asked a brief summary of what the problem was when reception staff received a call, notes were recorded and sent to the GP with a 'call back' request logged. The GP decided the priority order. The patients that called to receive a telephone consultation were not given the option to speak with their preferred GP and were told they would only receive one call back and therefore needed to ensure they stayed near the phone. Patients commented that this was not always convenient for them.

Appointments could be booked directly online and we noted that 32% of patients that completed the national patient survey had used this method.

There was information on the website and in the patient's booklet advising patients that they can call the surgery out of hours and receive information about how to access urgent care from a recorded message. The practice provided early morning appointments from 07:30 on Tuesday's, Wednesday's, Thursday's and Friday's.

Meeting people's needs

The practice had systems in place with secondary care providers to ensure information was available when a referral was made or when results were available. GP's could access blood test results from their computer systems. Any action requested by the hospital was communicated to the practice. The practice manager told us discharge letters for patients were regularly received at the practice, reviewed by the GP and updates were applied to patient's records with any new diagnosis and medications.

The practice had a higher number of older patients registered than the national and local CCG averages. To help manage the demand on access to see a GP the practice provided same day telephone consultations for patients. There was also the option to arrange a face to face consultation or a home visit if the patient had mobility problems.

Concerns & Complaints

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns, however this needed improvements. The complaints policy was not in line with recognised guidance and contractual obligations for GPs in England.

We found the process for patients to make a complaint was restricted. There was a notice displayed that referred patients to speak to the practice manager if they wanted to make a complaint. The practice booklet and the complaints information on the website also referred patients to speak to the practice manager. There was no information to get help for patients that may be vulnerable or where English was not their spoken language. Reception staff told us the practice manager holds the complaints forms and if patients want to make a formal complaint they are referred to the practice manger. When we reviewed the complaints form that is given to patients to complete we saw there was no information about how the complaint will be handled and the timeline within which it will be dealt with. There was no information available to the patients about the practice's complaints procedure in line with recognised guidance for GPs in England.

There was a designated responsible person who handled all complaints in the practice and this part of the process was followed appropriately. We reviewed a complaints report that was provided to us and saw it listed the number of complaints received in the period from April 2013 to February 2014. We noted there were nine complaints received by the practice. We looked at a summary and the processes followed. There was no information that any complainants had been dissatisfied with the response of the practice to their complaint.

However, when we spoke to staff about complaints received at the practice there was no evidence that learning points and actions were understood by the staff. There was no reference to any changes made as a result of the complaints recorded. We also noted there were a number of comments made on the NHS Choices website that are complaints about the poor care received at the practice during 2013/2014. There was no reference in the complaints reporting process on what improvements had been made as a result of patient's comments.

The practice manager had told us they were aware of the comments received through NHS Choices and the practice was working on improvements and engaging the practices patient participation group (PPG).

Are services well-led?

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

Our findings

Leadership & Culture

There was a management structure in place that consisted of a full time practice manager and the senior GP. The GP had clinical and financial responsibilities for the practice and the practice manager had operational and non-clinical responsibilities, for example managing administrative staff and the general administration and safety of the practice.

Both clinical and administrative staff described the culture within the service as being open and supportive. Staff told us they would have no hesitation to speak to the senior GP or practice manager if anything was troubling them because they knew they would be supported. We were told by staff they felt the management team valued them all individually for their role within the practice and they were all encouraged to fulfil their potential with support of the management.

Governance Arrangements

The practice held regular clinical and administration staff meetings. GPs and nurses held their own meetings when they needed to share specific patient cases and guidance related to their roles. Nurses felt fully involved in the clinical team meetings that were held and felt supported by the provider and the practice manager.

Staff had access to a range of policies and procedures which were kept up to date. We looked at several of the policies and saw that they were comprehensive and covered a range of issues such as health and safety, infection control and safeguarding. The policies and procedures were available to staff on line and staff told us that any changes were notified to them through meetings and email.

Systems to monitor and improve quality & improvement (leadership)

No clinical audits, other than those relating to prescribing, had been completed or were planned to evaluate clinical improvements for the treatment and care provided to patients. For example, there was no audit planned or completed to evaluate the treatment and diagnosis given during telephone consultations to understand how effective this was and what improvements could be made.

Patients had given mixed views about the service and there was no evidence to show if patients were still attending the surgery for consultations even after receiving telephone consultations.

Patient Experience & Involvement

Patients had completed the national GP patient survey and the practice's local survey and left comments to review on the NHS Choices website.

We had sent comment cards to the practice for patients to complete as they attended the practice two weeks in advance of our visit. We found on our arrival that there were no completed cards. We observed the comments box was displayed next to the reception window but there was no pen available for them to use.

Practice seeks and acts on feedback from users, public and staff

The Patient Participation Group (PPG) had four members all over 65 years of age. We were told they have actively tried to recruit more patients by advertising in the practice and on the website but there had been no interest received.

We met with one member during the inspection. They told us the PPG met two to three times a year and the meetings were usually attended by a practice manager and a nurse. At the last meeting there were some discussions about the complaints received by the practice and views were requested from the PPG. The PPG had suggested a practice survey with some specific targeted questions. The PPG member told us the questionnaire was not specific to the practice and it was a general one for all Hillingdon CCG practices so the results were not informative enough. We reviewed the 2013/14 report of the questionnaire that was posted up by the PPG on the practice website and noted some suggestions for improvements had been listed. In the list the PPG had suggested the practice make the complaints procedure more accessible to patients and the practice had commented that this had been completed. We found during our inspection these actions were not complete.

Management lead through learning & improvement

The practice was pro-active in identifying and delivering some individual professional development to improve staff expertise. For example the health care assistant had been

Are services well-led?

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

asked to complete certain specialist training to manage areas of services required. Staff were able to identify training which assisted them to provide specialised care to patients through their appraisals.

Identification & Management of Risk

We noted there were appropriate risk assessments for operational management to identify and manage risks to health and safety of patients and staff at the practice. For example a fire risk assessment had been completed in April 2014 and a Legionella risk assessment completed in July 2012. We also saw there were on-going infection control audits and cleaning audits completed regularly.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

One of the key priorities for the local CCG was to manage meeting the demand for elderly and frail patients and keeping them out of hospital by providing local access, treatment and care. All patients over 75 years of age had a designated GP to ensure they had continuity in their care.

The practice had a higher number of older patients registered than the national and local CCG averages. To help manage the demand on access to see a GP the practice provided same day telephone consultations for patients. There was also the option to arrange a face to face consultation or a home visit if the patient had mobility problems. The practice had not completed any audits to test how well this was working and the views we got from patients were mixed. One elderly person we spoke to told us they were unable to arrange a home visit when they had felt too frail. They also told us that they usually saw the nurse practitioner because the GP's were always booked up for face to face appointments.

We also spoke to an elderly couple that were complimentary about the service and felt all the staff were kind, caring and helpful. They liked the telephone consultation system because they found it difficult to go to the practice. They told us their GP knew all their health problems well and was confident with the advice they received over the telephone.

The practice also had arrangements to see elderly people as needed in three local care homes. One of the managers for the care homes that we spoke with told us they had no concerns and thought the telephone consultations worked well as the carers could help their residents sooner than having to wait for the GP to visit.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice told us there were systems in place to follow up reviews for patients with long term conditions. There were alerts recorded against the patient's electronic records that prompted clinical staff and admin staff to remind patients about any tests that may be due and to initiate a review if this was appropriate. There was a system in place that would generate recall letters for patients that may have forgotten about some follow up tests or a review that was due.

The practice used the national Quality and Outcomes Framework (QOF) for the clinical performance measures for long term conditions. Some examples of the areas of care assessed were diabetes, chronic obstructive pulmonary disease (COPD), stroke, asthma, epilepsy and hypertension. The recent 2012/13 QOF results showed the practice had achieved 100% in all these areas of care. This meant they reviewed patients regularly and followed up on any outcomes. We were told many of the on-going reviews were mainly carried out by the nurse practitioner and practice nurses. The Health Care Assistant (HCA) was also involved in assessing diabetic patients for healthy foot checks.

According to the QOF results, the practice were good at managing long term health conditions but there was no evidence of how well these clinical conditions were being managed through telephone consultations or face to face consultations.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

It was clear that some non clinical staff we spoke to did not have any training in the Gillick principles of obtaining consent from patients under 16 years of age. This could have an impact on patients under 16 years old that are trying to obtain treatment and advice for sexual health in confidence.

The practice provided antenatal care and postnatal care for mothers. If a patient was considered as having a complicated pregnancy the GPs offered regular checks to monitor the mothers' health. There were nurse-led baby clinics for mothers and young children that were generally for vaccinations but also for providing healthcare information and baby care.

There were nurse led clinics for women's health that provided smear tests, contraceptive advice and

information about sexual health. We saw evidence of regular monitoring of patients that had not received their routine smear tests and staff told us these patients were sent reminder letters.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice opened from 07.30 four days a week and 08.30 one day and stayed open until 18:30 for four days. This enabled patients who found it difficult to attend during normal opening hours due to work commitments to get an appointment when they needed one. Patients could book appointments online once they registered for login details.

There was also the telephone consultation system that was available however this received mixed views. Some patients commented that the system was good because they found it difficult to take time away from work especially if it was an urgent issue that they wanted to get some simple advice about.

Other patients who worked during normal working hours told us this system was difficult for them to use because they were not certain when they would receive a call back at a specific time from the practice. Some patients told us they had jobs where it was difficult for them to take a call when they were working or would not be able to discuss confidential information. This service did not provide flexibility for patients who needed to speak to a GP or nurse because calls were only made once by the clinician and there was no specific time allocated for the call.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice told us they knew who the registered patients were with learning disabilities and that there were not many. They offered support and worked jointly with social services to help the patients. One of the parents that we spoke to told us the GP from the practice was excellent with his son who had Down's syndrome. They told us the GP was always patient and understanding.

The practice told us it was difficult to register patients with no fixed abode as this was a requirement for registration with an NHS GP practice. They told us it was not an issue for the area that the practice was in because there was no identified group of this nature. They told us they would work proactively if it was an issue.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

Patients were referred by the GPs to secondary care if they were experiencing mental health difficulties. One of the GPs showed us the referral forms they used and these were detailed and comprehensive. The GP commented that the system had improved for patients and there were good integrated care pathways to support patients. The GP was able to illustrate a case and demonstrate their knowledge on the Mental Capacity Act 2005 (MCA). Both GPs we spoke with knew all their cases for patients with mental health illnesses. There were alerts set up on the patient's records for staff to put patients request first without any delays.

One of the GPs told us they had regular contact with the local 'Drug and Alcohol' team and discussed patients reviews as required and there was support from other local GPs that have a special interest in mental health.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The provider had not ensured that patient records were kept securely. Regulation 20 (2)(a)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The registered provider had not provided service users and those acting on their behalf with support to bring a complaint or make a comment, where such assistance is necessary.** **Regulation 19 (2)(a)(b)**