Dr Sashi Shashikanth

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at 'Dr Sashi Shashikanth', also known as West London Medical Centre, on 7 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services to the six population groups we inspect - People whose circumstances may make them vulnerable; Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); and People experiencing poor mental health (including dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles.
- There was a good skill mix amongst doctors and nursing staff with some clinicians having specialised areas of expertise.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Most patients said they found it easy to make an appointment. Urgent appointments were available the same day but may not be with a GP of the patient's choice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.
- A patient participation group had been formed and consulted with during 2014, however the practice had not communicated with the group this year.

Summary of findings

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

Importantly the provider should:

- Ensure availability of an automated external defibrillator (AED) or undertake a formal risk assessment if a decision is made to not have an AED on-site.
- Encourage the patient participation group to meet again so they can actively contribute to the continuous improvement of the service.
- Ensure staff are familiar with the practice's vision and values.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients who used services were assessed and well managed, such as those relating to infection control, medicines management, and business continuity. Whilst the practice had discussed the risks of not having an automated external defibrillator (used in cardiac emergencies), these had not been formally recorded. Portable equipment had been calibrated and tested for safety. We were told there were enough staff to keep patients safe. Staff who performed chaperone duties had received training and understood their responsibilities when acting as chaperones.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice had a process in place to follow-up vulnerable patients discharged from hospital, and we saw that the protocols for actioning hospital communications and test results were in place. Clinical staff worked with multidisciplinary teams and regular meetings were held. There was evidence of clinical audit to improve patient outcomes, and performance data showed patient outcomes were similar to or slightly below averages for the locality. For example, last year's performance for immunisations was similar to the local averages where comparative data was available. There was evidence of appraisals and personal development plans for staff who had been employed for over a year.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the national patient survey 2015, a patient satisfaction survey carried out by the practice, the GP principal's annual appraisal, and results from the Friends and Family Test showed that patients rated the practice well for several aspects of care. For example, the practice was similar to the CCG average for patients who were satisfied with consultations with the GPs, and consultations with the nurses were rated above the CCG averages. Patients said they were treated with compassion, dignity and respect and they were

Summary of findings

involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The majority of patients we spoke with were satisfied with the appointments system and said it was easy to use, although two patients found it difficult to get an appointment. The practice had recently taken action by recruiting an 'appointment coordinator' to liaise with patients having difficulty in accessing appointments. Patients confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be with the GP of their choice.

The practice had sought feedback from staff, patients, and the patient participation group, and had acted upon that feedback. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The GP principal was able to describe the practice's vision and a strategy, but not all staff were aware of this. There was a clear leadership structure and designated staff led in specific areas such as safeguarding, infection control and complaints. Staff felt management were approachable and supportive. The practice had a number of policies and procedures to govern activity and staff were aware of how to locate these. There were regular governance meetings although these were not recorded. There were whole practice meetings every three months and these were minuted. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from patients and staff. Feedback and consultation with the patient participation group (PPG) was active during 2014, however staff told us there had been no meetings with the PPG so far this year. Staff had received inductions, regular performance reviews and attended staff meetings and events. Staff were supported with mandatory training relevant to their role, however some staff said there was limited time to carry out further training.

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

Good

The practice is rated as good for the care of older people. The practice had a lower percentage of patients over the age of 75 (5.3%) than the national average (7.6%). The income deprivation level affecting older people was 22 compared to the national level of 22.5.

Nationally reported data showed that some outcomes for patients with conditions commonly found in older people were at or below the local and national averages. Staff were aware of where improvements were needed and had made changes to practice to improve these outcomes for patients. The practice offered personalised care to meet the needs of the older people in its population, for example all patients over the age of 75 had a named GP. It was responsive to the needs of older people, and offered home visits for those with enhanced needs. The practice also told us they had close working relationships with district nurses, the community matron service, and the rapid response team to discuss care planning for patients who required extra support. A community phlebotomy service, where patients were seen at home, was available for frail elderly patients who were unable to attend the hospital.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The percentage of patients at the practice with a long standing health condition or with health related problems in daily life were 47.3% and 41.7%. These were lower than the England averages of 54% and 48.8%.

Nursing staff assisted the GPs in chronic disease management. Patients with long term conditions were invited to a structured annual review to check that their health and medication needs were being met. A diabetic clinic was run every Friday and patients were able to see the GP and a diabetic specialist nurse for their review. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Longer appointments and home visits were available when needed.

Families, children and young people

Good

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

Summary of findings

The practice had more children aged 0 to 4 (10.1%) and 5 to 14 (12.5%) than the England averages of 6% and 11.4%. Overall, 15.4% of patients were under 18 years of age, compared to the national average of 14.8%. The income deprivation level affecting children was 30 compared to the national level of 22.5.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, health visitors were attached to the practice and attended multidisciplinary meetings to discuss children at risk. There was a designated GP who led on child protection, and all staff were aware of their responsibilities for safeguarding children. Immunisation rates were comparable to the local averages for all standard childhood immunisations. Appointments were available outside of school hours. Both antenatal and postnatal care was provided by the doctors, and patients were referred to the local hospital for midwifery clinics. The practice also offered advice on contraception and sexual health, and chlamydia screening was offered to patients opportunistically.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The number of patients in paid work or full-time education was higher than the national average, 77.5% compared to 60.2%.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended hours were available with the GPs from 07.30 on Wednesday morning, and with the nurses on Thursday evening till 19:00 and from 07.30 on Friday morning. The practice offered online services to book appointments and request repeat prescriptions. Telephone consultations were available and clinical staff offered advice over email when appropriate. There was a range of health screening programmes (including cervical and bowel cancer screening), and NHS health checks (for patients aged 40-75) that reflected the needs for this age group. Health promotion advice was offered and health promotion material was available at the practice and on the website.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including housebound patients, carers, and those with a learning disability. It

offered annual health checks for people with a learning disability and all 11 of these patients had received such a check-up. Longer appointments were also offered to patients with a learning disability.

The percentage of patients with a caring responsibility was lower than the national average at 10.9% compared to 18.2%. There were 31 patients registered as carers, and staff were aware of carers' needs and signposted patients to support services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Eighty four percent of people experiencing poor mental health had received an annual physical health check, and longer appointments were offered to these patients. The practice regularly worked with multi-disciplinary teams, including the community and hospital mental health teams, in the case management of people experiencing poor mental health. Patients were offered referral to emotional support services in the community such a drug and alcohol addiction service, and a child and adolescent service. The practice carried out dementia reviews and some clinical staff had received additional training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our inspection. Most were positive about the practice and their experience of the services provided. Patients said staff always treated them with dignity and respect, and they felt supported in making decisions about their care and treatment. They told us they were happy with the cleanliness of the environment and the facilities available. Five patients said they were able to get an appointment when they needed one, whereas two patients said they had difficulty getting an appointment. Urgent appointments were also available the same day, and patients told us they were aware that this may not be with the GP of their choice. We did not receive any CQC comment cards for this practice.

The National Patient Survey 2015 indicated that 86% of respondents described their overall experience of the practice as good, compared to the clinical commissioning group (CCG) average of 79% and national average of 85%. The practice received ratings similar to the CCG average for patients who were satisfied with GP consultations, and above the CCG average for consultations with the practice nurses. Patients rated the practice above the CCG average for questions about access to appointments, including their experience of making an appointment and getting through easily to the surgery by phone. Results from the Friends and Family Test January to March 2015 indicated that the majority of patients who responded were satisfied and would recommend the service.

Areas for improvement

Action the service SHOULD take to improve

• Ensure availability of an automated external defibrillator (AED) or undertake a formal risk assessment if a decision is made to not have an AED on-site.

• Encourage the patient participation group to meet again so they can actively contribute to the continuous improvement of the service.

• Ensure staff are familiar with the practice's vision and values.

Dr Sashi Shashikanth

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor. The specialist advisor was granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to Dr Sashi Shashikanth

Dr Sashi Shashikanth, also known as West London Medical Centre, provides GP led primary care services through a General Medical Services (GMS) contract to around 4,150 patients living in the surrounding areas of Hillingdon and Uxbridge. (GMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of Hillingdon Clinical Commissioning Group (CCG).

The practice staff comprise of five GPs (male GP principal, male sessional GP, three female GP locums), two practice nurses, a health care assistant, a practice manager, and a small team of reception / administrative staff. The GPs collectively cover 17 sessions per week. The nurses collectively work 32 hours per week and the health care assistant works eight hours.

The practice is located in a converted residential property with four consulting rooms on the ground floor and office space on the first floor.

The practice is open on Monday, Tuesday, Thursday and Friday from 08:00 to 12:30, and 14:00 to 18:00, and on Wednesday from 08:00 to 13:00. Appointments are available during these times. In addition, extended hours are offered with the GPs from 07.30 on Wednesday morning, and with the nurses on Thursday evening till 19:00 and from 7.30 on Friday morning. Appointments must be booked in advance over the telephone, online or in person. The practice opted out of providing out-of-hours services to their patients. Patients are directed to an out-of-hours telephone number between 12:30 to 14:00 on Monday, Tuesday, Thursday and Friday; on Wednesday afternoons from 13:00; and outside of normal opening hours. The practice website also refers patients to the NHS Direct helpline however this service ceased operation in March 2014.

The practice has a higher percentage (than the national average) of patients aged 0 to 17, and a lower percentage of patients over the age of 65. There is a lower percentage (than the national average) of people with a long standing health condition (47% compared to 54%), and a lower percentage (than the national average) of people with health related problems in daily life (42% compared to 49%). The average male and female life expectancy for the CCG area is similar to that of the national average.

The service is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures; treatment of disease, disorder and injury; surgical procedures; and maternity and midwifery services. The practice had previously been inspected during our pilot phase in August 2014, and we found shortfalls relating to cleanliness and infection control; requirements relating to workers; supporting staff; and records.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to look at the overall quality of the service. The practice had previously been inspected during our pilot phase in August 2014, and we have an obligation to conduct inspections at those practices that were inspected during our pilot phase in order 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?
- 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 that we held about the practice and asked other organisations to share what they knew. We also reviewed the practice's action plan following their previous inspection on 28 August 2014.

We carried out an announced inspection on 7 April 2015. During our inspection we spoke with a range of staff including: three GPs; a practice nurse; the practice manager; and three members of reception / administrative staff. We observed how people were being cared for and talked with carers and/or family members. We sought the views of seven patients on the day of inspection. We also reviewed the practice's policies and procedures. We did not receive any CQC comment cards.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a recent incident involving an urgent message not being communicated to the GP had been investigated, written up as a significant event, and shared with staff.

We reviewed safety records and incident reports for the last year, which showed the practice were managing these and could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of five significant events that had occurred during the two years and saw this system was followed appropriately. Staff told us that significant events and complaints were discussed at practice meetings, and we saw minutes to confirm this. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice's shared drive and sent completed forms to the practice manager. We saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, there was a significant event where a staff member had telephoned a patient at home and were told by a relative that the patient had passed away. The family were given an apology and the incident was shared with staff. In response to the significant event, the practice installed a whiteboard in reception and updated this with information on patients who had recently passed away. Alerts were also immediately put on the patient's record once a notification of death had been received so that all staff were aware.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, clinical staff had received an email alert on the interaction of two medicines from the Medicines and Healthcare products Regulatory Agency (MHRA).

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. For example, the GPs had received Level 3 child protection training, the nurses Level 2 or 3, and non-clinical staff Level 1 or 2. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice also worked with other health and social care professionals such as social workers, health visitors and midwives, and a local women's centre if they had concerns regarding a patient.

There was a chaperone policy, which was visible in the waiting room and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Clinical and three non-clinical staff acted as chaperones. Staff had received online and in-house verbal training to be a chaperone and understood their

responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Repeat prescriptions could be requested in person, online, via e-mail, post, fax or by pharmacist request. It was practice policy not to accept requests over the phone. Administrative staff generated authorised repeat prescriptions and all prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescriptions were tracked and stored securely.

The management of patients taking high risk medicines, such as methotrexate, was via a shared-care protocol with the hospital. The practice could access the hospitals records to review patients' blood test results, and appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were up to date. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received in-house training about infection control specific to their role. We saw evidence that an audit was carried out in February 2015 and any improvements identified for action were completed on time. For example, fabric chairs in the consultation rooms had been replaced with wipeable chairs.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had also received an external risk assessment on 2 February 2015 for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). An action plan had been developed following the assessment and the practice's cleaning supervisor made aware so that the changes could be implemented.

Equipment

Staff we spoke with told us they had 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 tested and displayed stickers indicating the last testing date which was 18 March

Good

Are services safe?

2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment on 31 March 2015; for example weighing scales, and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff, however we noted that this did not include pre-employment recruitment checks such as checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We were told that DBS checks were carried out for all clinical staff, and non-clinical staff who acted as chaperones. 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 and the appropriate DBS checks.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a system in place for all the different staffing groups to ensure that enough staff were on duty. The GP principal also told us that members of staff would assist to cover each other's annual leave, and staff worked extra hours when there was an increased demand for the service. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy, and health and safety information was displayed for staff to see.

The practice kept paper and electronic patient records. Electronic records were password protected and could only be accessed by authorised staff. Patients' paper records were stored securely in lockable cupboards.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to medical oxygen. When we asked members of staff, they all knew the location of the emergency equipment and records confirmed that it was checked regularly. The practice did not have an automated external defibrillator (AED) which is used in cardiac emergencies. Staff told us they had discussed the risks of not having an AED and decided that as the local hospital was a few minutes from the practice the risk was low, and staff were advised to call 999. Their risk assessment was also based on a significant event last year when during a medical emergency an ambulance had arrived at the practice in less than four minutes. The practice had not formally documented this risk assessment.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, asthma, and chest pain. Processes were also in place to check whether 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. Risks identified included power failure, incapacity of staff and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had a fire safety policy which identified named staff members as nominated fire marshals. The fire marshals had received training to carry out this role, and fire safety training was provided to staff during induction. There was a notice in reception which outlined the actions to take in the event of a fire and where the assembly point was during an evacuation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners, including local referral pathways, was accessible to staff electronically. The GPs told us they attended educational meetings held at the local hospital and with the CCG, and NICE guidelines were reviewed here. Information was then disseminated to relevant staff during practice meetings or by email. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. The GP principal and a diabetic specialist nurse held clinics every Friday for patients with diabetes. The GP explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks with the GPs and nurses. The practice's performance was however, below the CCG and national averages for patients with diabetes who had a blood pressure reading in the preceding 12 months of 150/90 mmHg or less (practice 86.9%, CCG 93.2%, national 91.7%); patients with diabetes with a record of a foot examination and risk classification within the last 12 months (practice 74.5%, CCG 87.1%, national 88.3%); and patients with diabetes who had received the seasonal flu vaccination (practice 82.6%, CCG 94.8%, national 93.4%). The practice was aware of areas where performance was not in line with national or CCG figures and staff were given specific areas to focus on to address this.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. There were no structured meetings for clinical staff, although the GP principal told us that he met with the GP locums after each clinical session to discuss any concerns, receive a handover, and discuss new local and national guidelines that were relevant. The GPs locums confirmed these debrief sessions were useful.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly by the practice or referred to the rapid response team who were able to visit the patients at home, and reduce the need for them to go into hospital. The GP principal told us that when vulnerable patients including those with unstable long-term conditions or frail elderly patients were discharged from hospital, they were followed up by the rapid response team to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts, and medicines management. The information staff collected was then collated by the GPs to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last year. One of these was a completed audit cycle on patients with ischaemic heart disease (IHD) on antiplatelet medication where the practice was able to demonstrate the changes resulting since the initial audit. The initial audit had been carried out in August 2014, and a re-audit took place in March 2015. The initial audit had indicated that five patients with no contraindications should have been on antiplatelet medication. These patients were subsequently contacted for a consultation. The re-audit showed that patient outcomes had improved, as all patients with IHD with no contraindications were now on antiplatelet therapy. The GPs told us clinical audits were often linked to medicines management information. Monthly medicine audit data was sent to the CCG, and we saw evidence of this taking place since 2014.

The practice used the information collected for the quality and outcomes framework (QOF) and national screening programmes to monitor outcomes for patients. (QOF is a

Good

Are services effective?

(for example, treatment is effective)

voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice achieved 90.1% of the total QOF target in 2014 (CCG average 91.3% and national average 93.5%), and 86.3% for the clinical domain (CCG average 90.6% and national average 92.3%). This included meeting the minimum standards for QOF in dementia, depression, epilepsy, heart failure, hypothyroidism, and osteoporosis. It did not achieve all the standards for other areas under the clinical domain, which included chronic kidney disease (achieving 24.72 out of 32 points), chronic obstructive pulmonary disease [COPD] (33.58 out of 35 points), and diabetes (88.78 out of 107 points). The practice were aware of the outcomes being achieved and areas for improvement. There were no documented action plans, although clinical and non-clinical staff were able to describe their roles in improving outcomes for patients, for example reminding patients when their annual review was due and following this up if patients had not responded. We could not access the QOF data for 2015, however staff informed us that improvements had been made and the practice had achieved 95.3% overall and 97% for the clinical domain.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, such as patients with learning disabilities and patients receiving palliative care. Structured annual reviews were also undertaken for people with long term conditions such as diabetes, COPD and asthma. Although QOF data showed that the practice were below the CCG and national averages for patients who had received an asthma review in the preceding 12 months (practice 60.5%; CCG 76.5%; national 75.5%).

The practice told us they participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. Data showed that the practice had outcomes that were similar to national figures for prescribing. There was a protocol for repeat prescribing. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. The IT system also flagged up relevant medicines alerts when the GP was prescribing medicines.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had a training matrix which highlighted when staff training required updating. We reviewed training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, health and safety, safeguarding adults, child protection, and infection control. We noted a good skill mix among the doctors with some having additional diplomas in urgent care, diabetes, family planning, children's health, obstetrics and gynaecology.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice provided mandatory training however, there was often a lack of time for staff to undertake training in other areas of interest. Staff files we reviewed showed that where poor performance had been identified, appropriate action had been taken to manage this.

Practice nurses and the health care assistant had job descriptions outlining their roles and responsibilities incorporated into their contracts. We saw they were trained appropriately to fulfil these duties, for example administering vaccines and providing smoking cessation advice. One of the nurses had an extended role of seeing patients with long-term conditions such as diabetes, asthma, and CHD, and was able to demonstrate that they had additional diplomas and appropriate training to fulfil these roles. Both nurses were due for an appraisal as they had now been employed for a year, and we were told that this would take place within the next month.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, both electronically and by post. Out-of-hours reports were received by fax each morning before the start

Good

Are services effective?

(for example, treatment is effective)

of surgery. Out-of hours reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt if they were urgent, or within three days for non-urgent matters. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. We were advised there had been no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were 21.52%, compared to the national average of 13.6%. The GPs told us that the community matron service and rapid response teams were used to avoid unplanned hospital admissions for vulnerable patients, such as the frail elderly, and those with long term conditions.

The practice held quarterly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, housebound patients, those from vulnerable groups, patients with end of life care needs or children on the at risk register. These meetings were attended by district nurses, community matron, health visitors, and palliative care nurses to discuss care planning for these patients, and we reviewed minutes to some of these meetings. The practice also worked with the community mental health teams and hospital psychiatric teams for patients experiencing a mental health crisis.

Information sharing

We saw evidence that there was a system for sharing appropriate information for patients with complex needs, including those in receipt of palliative care, with the out-of-hours services. Electronic systems were in place for making referrals via the local referral pathways or the 'choose and book' system. The GP principal met with the other GPs at the end of their clinical sessions to assess the appropriateness of referrals, and referrals were then sent to specialist services in the community or hospital. The GP principal told us about a recommendation he had made regarding the referral pathway to a drug and alcohol addiction service, and as a result patients were now referred directly to the service from the community rather than needing to see their GP for a referral.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. We saw evidence that clinical staff had received training in dementia awareness and mental health.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for children, and specific interventions. For example, patients' verbal consent to treatment was record in the electronic patient notes, and written consent was obtained for minor surgical procedures.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years however, practice data showed the uptake was low with 5% of patients in this age group taking up the offer of the health check. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering

Good

Are services effective?

(for example, treatment is effective)

opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The nurses were also involved in offering patients support with contraception and sexual health. Health promotion information was available to patients in the waiting room, consulting rooms, and on the practice website.

The practice had ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability. Practice records showed all 11 patients had received a check up in the last 12 months. Annual physical checks and mental health reviews were offered to patients on the mental health register, and 84% of patients had received their annual review. The practice had a palliative care register and there was one patient currently listed on the register. These patients received end of life care and further support in line with their needs.

The practice's 2014 performance for the cervical screening programme was 69.8%, which was below the CCG average of 77.9% and national average of 81.9%. They told us they had improved on this by achieving 73% for the 2015 uptake, however they were aware that this still required improvement. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was average for the majority of immunisations where comparative data was available. For example, flu vaccination rates for the over 65s were 71.69%, and at risk groups 52.35%. These were similar to the national averages. Childhood immunisation rates for the vaccinations given to under twos ranged from 88.1% to 94% and five year olds from 81.7% to 95.1%. These were comparable to CCG averages.

Good

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 national patient survey 2015 (127 responses received), a patient satisfaction survey carried out by the practice in 2014 (150 responses received), patient feedback received for the GP principal's annual appraisal 2014, and results from the Friends and Family Test (a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses). The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey 2015 showed that 86% of respondents described their overall experience of the practice as good, compared to the clinical commissioning group (CCG) average of 79% and national average of 85%.

Data from the national GP patient survey 2015 showed that the practice was similar to or slightly below the CCG and national averages for patient satisfaction scores on consultations with the GPs. For example, 84% of respondents said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%. Seventy seven percent said the GP gave them enough time compared to the CCG average of 81% and national average of 87%.

Satisfaction scores for consultations with the nurses was above the CCG average and similar to the national average. For example, 90% of respondents said the nurse was good at listening to them (CCG average 85%, national average 91 %), and 91% said the nurse gave them enough time (CCG average 86%, national average 92%).

Results from the Friends and Family Test January to March 2015 indicated that the majority of patients who responded were satisfied with the service they received. For example, in January six patients said they were 'extremely likely' or 'likely' to recommend the service, and one said they were 'unlikely' to. In February the figures were ten and four, and March were eight and three respectively. There was a range of Information leaflets in reception to help patients understand the services available.

Patient feedback from the GP principal's appraisal showed that patients were satisfied with the care they received and said the GP was helpful, caring and supportive. We did not receive any CQC comment cards. We spoke to seven patients on the day of our inspection. All these patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by clinical and non-clinical staff. Results from the practice's survey aligned with these views.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy screens were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located at the back of the reception office and a glass partition at the reception desk could be closed to keep patient information private. We observed this occurring during our inspection. Staff told us that a room within the practice could be used to prevent patients overhearing potentially private conversations between patients and reception staff, and we saw a poster informing patients of this. Additionally, the national GP patient survey showed that 90% found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

The national patient survey 2015 showed that respondents rated the practice lower than the CCG and national averages to questions about their involvement in planning and making decisions about their care and treatment. For

example, 73% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 82%. Seventy six percent said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and national average of 86%.

Satisfaction scores for consultations with the nurses were similar to or below the CCG and national averages, as 79% said the nurse was good at involving them in their care (CCG average 80%, national average 85%), and 87% said the nurse was good at explaining tests and treatments (CCG average 84%, national average 90%). The majority of patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff.

Staff told us that translation services were available for patients who did not have English as a first language, although we did not see notices informing patients this service was available. Some staff could also speak languages other than English, which aided communication with some patients.

Patient/carer support to cope emotionally with care and treatment

Patients were offered referral to emotional support services in the community such as the mental health team, a drug and alcohol addiction service, and a child and adolescent service.

The national patient survey showed that respondents rated the practice similar to or below the CCG and national averages about the emotional support provided by the practice. For example, 78% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and national average of 85%. Eighty eight percent said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 90%. The patients we spoke with on the day of our inspection told us they received emotional support from the practice.

The percentage of patients with a caring responsibility was lower than the national average at 10.9% compared to 18.2%. The practice had 31 patients registered as carers, and the practice's computer system alerted GPs if a patient was a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

A noticeboard in the reception office informed staff of patients who had recently passed away to ensure staff did not attempt to contact the patient. Staff told us that if families had suffered bereavement, the practice would send a letter of condolence and support. Patients were invited to the practice to speak with the GPs, or signposted to support services such as bereavement counselling.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The GP principal told us that he engaged regularly with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice utilised the rapid response team who visited vulnerable patients at home. This included patients with an exacerbation of chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF), patients with unstable diabetes, patients at end of life, and elderly frail patients at risk of admission to hospital. A diabetic clinic was run every Friday and patients were able to see the GP and a diabetic specialist nurse for their review.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and patient survey. For example, the need to review and improve the availability of appointments had been identified by patients and the PPG in 2014, and as a result the practice had recruited an 'appointment coordinator' to manage patients who were unable to get an appointment when they needed one. The appointment coordinator spent more time speaking to patients to find out if their request was urgent, if they could see a nurse rather than a GP for their condition, or take further details for requests such as referral letters or fit notes. The practice told us this assisted the GPs in dealing with urgent cases. More telephone consultations were also used to ease the burden on the demand for face to face consultation. The appointment coordinator had been in post for one month and the practice had yet to review the success of this system. The PPG had also suggested increasing the availability of nurse appointments. As a result the practice had employed two nurses who between them offered daily appointments, however further appointments could not be offered due to the availability of rooms.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, and patients experiencing poor mental health. The majority of the practice population were English speaking patients, but access to telephone translation services was available when needed. Some clinical and non-clinical staff spoke languages other than English, which aided communication with patients. Staff told us that patients with hearing problems were supported as the practice had a portable hearing loop, and a sign language interpreter could be booked in advance.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as patient facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. The waiting area could accommodate wheelchairs and prams, and there was a sheltered area outside the practice where patients could leave mobility scooters or prams.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records. For example, to identify patients who were housebound, receiving palliative care, or patients with learning disabilities. The GP principal was the named GP for all patients over the age of 75. The practice did not currently provide a service to any patients in care homes or nursing homes.

Patients could choose to see a male or female GP. The practice had an equality and diversity policy in place and staff had received training.

Access to the service

The practice is open on Monday, Tuesday, Thursday and Friday from 08:00 to 12:30, and 14:00 to 18:00, and on Wednesday from 08:00 to 13:00. Appointments were available during these times. Extended hours were offered with the GPs from 07.30 on Wednesday morning, and with the nurses on Thursday evening till 19:00 and from 07.30 on Friday morning. These were particularly useful to patients with work or educational commitments, as the practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

had a higher percentage of patients in paid work or full-time education (77.5%) compared to the national average (60.2%). Appointments could be booked in advance over the telephone, online or in person. Information was available to patients about appointments in the practice leaflet and on the website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. For example, 999 in a medical emergency, or an out-of-hours telephone number if their medical problem could not wait until the practice was open. Patients were directed to the out-of-hours telephone number between 12:30 to 14:00 on Monday, Tuesday, Thursday and Friday; on Wednesday afternoons from 13:00; and outside of normal opening hours.

Same day emergency appointments were available in the morning and afternoon. Longer appointment times were available for those who may need them including patients with complex conditions; antenatal and postnatal care; and annual reviews for patients with long term conditions such as diabetes and asthma. Home visits were made to patients who needed one, including housebound patients, and the frail elderly. The GP principal told us that telephone consultations and email advice from the doctors and nurses was also provided to patients who found it difficult to access the practice. A community phlebotomy service was available for frail elderly patients who were unable to attend the hospital for blood tests.

The national patient survey 2015 information we reviewed showed patients rated the practice similar to or above the CCG and national averages for questions about access to appointments. For example, 71% were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 76%; 74% described their experience of making an appointment as good compared to the CCG average of 69% and national average of 74%; 84% said they could get through easily to the surgery by phone compared to the CCG and national average of 74%; and 64% said they usually waited 15 minutes or less after their appointment time compared to the CCG and national average of 65%. The majority of patients we spoke with were satisfied with the appointments system and said it was easy to use, although two patients told us that they found it difficult to get an appointment and they usually waited over 20 minutes after their appointment time. Patients confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be with the GP of their choice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the practice manager was the designated responsible person who handled all complaints in the practice. Complaints were discussed in staff meetings, or sooner if required, and staff we spoke with were able to outline what to do if a complaint was made to them. Staff told us that wherever possible they tried to de-escalate problems and deal with concerns immediately.

We saw that information was available to help patients understand the complaints system in the practice leaflet and on the website. Some patients we spoke with were aware of the process to follow if they wished to make a complaint, and others told us they would request the information from staff. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice provided us with a copy of its complaints log for 2015. The log indicated that there had been six complaints received in the last four months. The majority of these related to conversations between patients and doctors. The practice had documented the action taken and learning achieved. For example, one patient had commented on the attitude of a member of staff. The incident was shared with the member of staff and a letter of apology was sent to the patient. The complaint was shared with staff so that they were reminded that their demeanour may be misinterpreted by patients. Five complaints had been handled satisfactorily, and one complaint was ongoing and being investigated by an external organisation.

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 did not have a formalised vision or strategy, and practice values had not been documented or shared with staff. The GP principal was able to describe the practice's vision and strategy for improving services provided for patients and ensuring the practice's premises and environment were safe and fit for purpose. There was also a focus on the proactive management of long-term conditions. Other staff spoke about the importance of providing patient-centred care however, they were not aware of a formalised vision or strategy for the practice. We did not see any information on values displayed within the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a folder in the administration office. We looked at 26 of these policies and procedures, including those relating to health and safety, infection control, safeguarding, complaints, consent, referrals, significant events, data protection, and business continuity. The policies and procedures we looked at had been reviewed annually and were up to date, and staff we asked knew how to locate these documents.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP principal was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Since our last inspection the senior administrator had been appointed as practice manager. The GP principal and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it had achieved 90.1% of the total QOF target for 2014, which was just below the local and national averages of 91.3% and 93.5% respectively. We saw that QOF data was regularly discussed at monthly team meetings and individual staff members had roles to maintain or improve outcomes.

The practice also carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit on hypertension showed that 40% of patients had not achieved the follow-up planned and as a result the practice had reviewed their follow-up procedures to recall patients. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the clinical commissioning group (CCG).

The practice identified, recorded and managed risks to patients, staff and visitors to the practice. For example, risks relating to fire safety, business continuity, and infection control had been carried out. Whilst the practice had discussed the risks of not having an automated external defibrillator (used in cardiac emergencies), these had not been formally recorded. We were told governance meetings were held between the GP principal and practice manager to discuss performance, quality and risks however, these were informal and not recorded.

The GP principal and practice manager were responsible for human resource policies and procedures. We reviewed a number of policies, for example the newly employed staff policy and appraisal policy, which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the policy folder.

Leadership, openness and transparency

The GP principal and practice manager were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. Staff were encouraged to contribute to discussions about how to improve the service delivered by the practice.

We saw from minutes that team meetings were held every three months. Staff told us that there was an open culture

Are services well-led?

Good

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

within the practice and they had the opportunity to raise any issues at team meetings and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the GP principal and practice manager.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys, the Friends and Family Test, patient feedback from the GP principal's annual appraisal, and complaints received. In 2014 the practice had met with the PPG on three occasions, however staff told us the PPG was less active during 2015 and there had been no meetings so far. The practice manager told us the plan was to redevelop the PPG, however we did not see what actions the practice had put in place to do this.

The practice manager showed us the analysis of the last patient survey carried out in 2014, which was considered in conjunction with the PPG. The results and actions agreed from these surveys was available on the practice website. A common theme emerging from patient feedback related to the availability of appointments, and the practice had recently taken action to address this by recruiting an appointment coordinator who assisted in improving access to appointments. The practice planned to review the success of this system during the next patient survey.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

We looked at staff files and saw that regular appraisals, which included a personal development plan, were in place for staff who had been in post for a year or more. The practice nurses had yet to undergo an appraisal as they had now been in post for a year this month, and the management were aware that the nurse's appraisals were now due. Staff told us that the practice provided them with mandatory training such as basic life support, safeguarding, and health and safety, although they stated they did not often have time to undertake training in other areas of interest.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings, or sooner if urgent, to ensure the practice improved outcomes for patients. For example, folding chairs were no longer used for safety reasons following an incident with a patient. We spoke to clinical and non-clinical staff and they were all aware of recent incidents that had occurred at the practice.

The GP principal was a GP appraiser, and also managed an independent support and educational group for sessional GPs in Hillingdon. The other GPs confirmed they attended these educational sessions, and the sessional GP told us he represented the practice at bimonthly locality meetings. Information from educational events and meetings were cascaded to relevant practice staff via email.