The Practice Feltham Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Practice Feltham Centre on 18 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring and responsive services. It was also good for providing services for all six population groups.

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 and any further training needs had been identified and planned.

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.

Patients said they found it easy to make an appointment and that there was continuity of care.

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.

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

Importantly the provider should:

Ensure an annual infection control audit takes place.

Ensure staff receive mental capacity act training.

Ensure all staff at the practice have the opportunity to attend staff meetings and these are recorded.

Summary of findings

Continue to promote the Patient Participation Group to enable the practice to listen to patients and identify further improvements in patient care.

Ensure that all staff at the practice have an annual appraisal.

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 to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

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 we saw evidence of this when we looked at an audit which had been completed by the practice. All new patients received a health check which included promoting good health. Staff had received training appropriate to their roles and stated the practice supported them to develop and attend training. Overall there was evidence of appraisals and personal development apart from non clinical staff who did not have an appraisal record. Staff worked with multidisciplinary teams and attended peer group meetings and clinical development sessions with the local Clinical Commissioning Group (CCG).

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. 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 NHS England and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice was open from 8:00am to 8:00pm during the week. The practice had reviewed the appointment system and the capacity of GPs to meet patient need. As a result, changes had been made to the appointment booking system and new patient health check registration. The practice had

Summary of findings

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.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff understood the ethos of the practice and how they would achieve good patient care. However, a formal vision and strategy statement had not been developed.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

The practice was in the process of promoting membership of the Patient Participation Group (PPG) to patients. The PPG was advertised in the reception area and on the practice website. The practice had used patient feedback to inform service development. The practice had analysed feed back given by its patients in response to the 2014 GP Patient Survey. An action plan had been developed to address identified areas of improvement.

Clinical staff were appraised annually and attended staff and peer group meetings. Reception staff did not have a formal recorded appraisal or attend regular staff meetings.

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 number of older patients registered with the practice was significantly lower than the England average. The practice offered proactive, personalised care to meet the needs of the older people. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Additional home visits had been initiated when GPs noticed that they were receiving repeat prescription requests for older patients they had not seen at the practice for a considerable length of time. A summary of older patients care needs was held on their electronic record. All of the patients who were eligible were invited to the practice for their annual flu vaccine.

GPs attended monthly meetings with the aim of enhancing their knowledge of caring for patients in this age group. Meeting topics included care planning, dementia and mental health. The meeting was attended by a consultant, the community matron and social services. The safeguarding lead for the practice usually attended these meetings.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. GPs and the practice nurse had lead roles in chronic disease management. The lead GP for diabetes management saw all of the patients with type 2 diabetes. Patients at risk of hospital admission and requiring a prompt appointment were identified as a priority on their electronic record. Longer appointments and home visits were available when needed. All these patients had a named GP and a summary of their care was held on the electronic patient record. 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, children who were on the social services risk register. Immunisation rates were in line with childhood immunisations for Hounslow CCG . Where a parent from overseas could not confirm or did not have a record of childhood immunisations, these were initiated by the practice and the required immunisations were administered. The lead GP for asthma care had

Summary of findings

a special interest in paediatric and childhood asthma. GPs at the practice made an internal referral to the lead when childhood asthma had been diagnosed. Appointments were available outside of school hours and the premises were suitable for children and babies.

Staff told us that they were aware of Gillick Competency (when a child is able to consent to their own medical treatment without parental permission) and children and young people were treated in an age-appropriate way.

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 practice provided extended opening hours. It was open five days a week and remained open until 8:00 pm daily for routine and emergency appointments. The practice also offered telephone consultations. The practice offered on-line appointments and repeat prescription services and an in-house phlebotomy service. The choose and book system was used by the Referral Facilitation Service (RFS) to enable patients to arrange the date of their initial appointment after referral. The nurse, healthcare assistant and clinical staff provided health promotion. Patients could be referred to the smoking cessation service which was located in the same building as the practice.

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 electronic recording system identified patients who were deemed vulnerable. There was a safeguarding lead who was available to offer advice and support to staff if they were concerned about a particular patient. 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.

Clinical staff told us they would not turn a person away who required medical treatment, even if they were unable to produce the correct documentation to register. Staff had a cultural awareness of issues which may affect the health and wellbeing of women in the ethnically diverse community.

Summary of findings

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. The practice worked with multi-disciplinary teams based at a local Hospital and a local Mental Health Trust for the case management of people experiencing poor mental health, including those with dementia.

Patients were referred to the Improving Access to Psychological Therapies Service for Cognitive Behavioural Therapy (CBT) and the management of stress and anxiety disorders. Referrals were also made to a local drug and alcohol treatment team where patients had been assessed as requiring support with addictions.

Summary of findings

What people who use the service say

We spoke with three patients during our inspection and received 17 comment cards, completed by patients who visited the practice during the two weeks prior to the inspection.

Patients we spoke with made positive comments about their experience of the practice and the appointments system. Patients said they were able to get an appointment in a reasonable time. Patients said they were pleased with the online booking system, and that the appointment confirmation text messaging service was useful.

Comment cards indicated that patients were happy with the service they received at the practice. All of the comments cards contained positive information about staff who patients said were caring and friendly. Patients said staff were always professional and treated them with dignity and respect. Patients commented that reception staff were helpful and efficient. Patients had observed the practice to be clean and tidy.

The results from the 2014 National Patient Survey showed that 79% of respondents had confidence and trust in the GP they saw. Fifty-one per cent of patients would recommend the practice to someone new in the area. Sixty per cent said it was easy to get through on the phone, the CCG average for this was 74% .Sixty one per cent of patients usually had to wait less than fifteen minutes when they arrived in comparison to 74% within the CCG area.

Areas for improvement

Action the service SHOULD take to improve

Ensure an annual infection control audit takes place.

Ensure clinical staff undertake training in the Mental Capacity Act.

Ensure all staff at the practice have the opportunity to attend staff meetings and these are recorded.

Continue to promote the Patient Participation Group to enable the practice listen to patients and identify further improvements in patient care.

Ensure that all staff at the practice have an annual appraisal.

The Practice Feltham Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector, a second inspector and a GP specialist advisor. The GP specialist was granted the same authority to enter the premises as the CQC inspectors.

Background to The Practice Feltham Centre

The Practice Feltham Centre is located in Brentford in the London Borough of Hounslow, and provides a general practice service to around 7,164 patients. The practice is located in the Feltham Centre for Health which is based in a shopping centre. The Feltham Centre for Health also provides three other GP practices which are not linked to The Feltham Practice. The reception area for all of the practices is open plan, with each practice allocated a separate reception and patient waiting area.

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

The Practice Feltham Centre provides primary medical services through an Alternative Provider Medical Services (APMS) contract. An APMS contract is commissioned from a non-NHS body, such as voluntary or commercial sector provider. The Practice Surgeries Limited holds the APMS contact for a number of practices in Hounslow including The Practice Feltham Centre.

The practice is open five days a week from 8:00am to 8:00pm. The practice has opted out of providing out-of-hours service to patients, and out of hours patients were advised to ring the local out-of-hours provider.

The practice has a higher than average number of patients aged between 46 and 65 years and a low number of patients above the age of 75 years. The Feltham Practice Centre had been open for several years, and was located in a residential area which provided housing for families.

The practice team is made up of five salaried GPs and two practice nurses one of whom is a nurse prescriber. The practice nurses worked a total of ten sessions a week. A full time health care assistant is employed. Seven receptionists are employed at the practice to cover the reception area on a rota basis, during opening times.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

- Is it safe?

Detailed findings

- 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 carried out an announced visit on 18th November. During our visit we spoke with a range of staff including the practice manager, two GPs, one practice nurse, the health care assistant, and reception staff. We observed how patients were being spoken with and spoke with three patients. We reviewed 17 CQC patient comments cards where patients had shared their views and experiences of the service with us.

Good

Are services safe?

Our findings

Safe track record

Arrangements were in place to identify risks and improve patient safety. National patient safety alerts were received on the electronic recording system and discussed at clinical meetings. Reception staff told us they were informed separately of national patient safety alerts. Staff we spoke with were aware of the incidents and issues that required reporting, including safeguarding concerns and were clear about their role to report issues to the lead GP or practice manager. There were suitable policies and procedures in place for safeguarding infection control and health and safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. There was evidence of a format for recording events and 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 and they felt encouraged to do so. One member of staff explained how they had reported a significant event and said this had been acted upon. We saw evidence of action taken as a result of a prescribing error. As a result of the prescribing error a process was put in place to review and check prescribing for patients with specific conditions.

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. All clinical staff had received safeguarding adults training, and child protection training to level 3. Non clinical staff received online 'core skills training' in safeguarding adults and child protection to level 1. A GP was designated as the safeguarding lead. Reception informed us that staff policies and procedures on child protection and safeguarding could be found in the practice online folders.

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. The staff we spoke with said if they had concerns they would talk to the safeguarding lead. However, staff knew that they were able to escalate concerns to social services if they were required to do so. Contact details were easily accessible; posters were available in clinical rooms detailing safeguarding contact names and telephone numbers.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. GPs attended safeguarding meetings when it was possible to do so. If the GP was not able to attend the patients electronic record was updated once a record of the meeting was received.

Vulnerable patients were coded on the electronic patient record. The practice had developed a template to identify and risk assess vulnerable patients. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plans. All patients under the age of sixteen who registered with the practice were checked against the Hounslow Social Services list of children on the risk register. Minutes of safeguarding meetings were stored on the electronic patient record with a record of the outcome.

Staff had received in-house training in chaperoning patients. All staff were DBS checked. Posters were displayed in clinical rooms informing patients that they could request a chaperone.

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. 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. The health care assistant was responsible for stock control and monitoring the temperature of the medicine fridges.

Good

Are services safe?

Storage cupboards for medicines contained an inventory list detailing the drug description and expiry date. We saw that medicines which were close to their expiry date had been highlighted.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. A member of the nursing staff was qualified as an independent prescriber and had received training to carry out her role in 2014.

Staff we spoke with were aware of the requirement to store vaccines at the correct temperature and described the action they would take in the event of a problem. We saw that medicines stored in the fridge were in date and that fridge temperatures were checked twice a day. The practice had a policy/guidance for storage, stock control and maintenance of the cold chain for vaccines and other medicines; this had been reviewed in 2010. A second fridge was kept at the practice; this was kept empty to be used in the case of an emergency.

All prescriptions were reviewed and signed by a GP before they were given to the patient. There was an automatic safety check for repeat prescribing on the electronic recording system. Medication reviews were undertaken every six months for patients with long term conditions.

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.

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 had received infection control training as part of their induction. An infection control policy and supporting procedures were available for staff. Guidance for staff on the safe management of clinical waste and handling blood samples was on display. The healthcare assistant undertook audits on hand washing and the cleanliness of clinical rooms; however we saw that the last audit to be carried out was dated November 2013.

Hand washing posters were seen in the clinical rooms as was a flow chart poster for the safe disposal of sharps needles. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (Legionella is a germ which can contaminate water systems in buildings). We saw records that confirmed a contract was in place for legionella testing for the whole building. [ML1]

Equipment

The practice had appropriate equipment to carry out examinations and assessments including blood pressure monitoring machines, weighing scales and nebulisers. A contract was in place to carry out equipment calibration annually and records confirmed this had been done.

Staffing and recruitment

We looked at the records of all of the staff at the practice which confirmed that the appropriate recruitment checks had been obtained prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). When doctors and nurses were employed their qualification and registration with either the General Medical Council or Nursing and Midwifery Council were checked, staff records we saw confirmed this.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Once recruitment checks had been obtained these were forward to the Human Resources Department who then gave final approval for the candidate to be employed.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Good

Are services safe?

The practice had carried out an annual fire risk assessment in December 2013 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practiced regular fire drills.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Training records confirmed that all staff had received training in annual basic life support. Emergency equipment was available including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff confirmed that emergency equipment was checked regularly. Two oxygen cylinders were kept at the practice with a recorded expiry date of 2017. The practice defibrillator was calibrated annually. The self-adhesive pads used with the defibrillator were due to expire in March 2015. Portable appliance testing took place in January 2013 and was due to be repeated in 2015.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. An inventory was made of the medicines contained in the emergency medicines kit and the expiry date of each medicine was recorded. 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, for example staff shortages and adverse weather conditions. Staff had clear guidance about actions they should take in the event of a range of emergency situations.

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. GPs informed us that they were able to refer to NICE guidelines and guidance from Hounslow Clinical Commissioning Group on the provider intranet. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GP's informed us that they met monthly to discuss best practice guidance and clinical care. One of the two GPs attended monthly seminars at a London hospital to keep up to date with developments in clinical care.

GPs told us that they made referrals and provided treatment depending on patient need. The practice used the Referral Facilitation Service (RFS) for patient referrals to secondary care. The GP completed the relevant referral template which was forwarded to the (RFS) electronically. Once this had been completed the patient was contacted by the RFS who managed the 'choose and book' system'. The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

Management, monitoring and improving outcomes for people

The practice had a system for completing clinical audits. We were shown an example of one completed clinical audit and one non clinical audit. The practice had reviewed the prescribing of vitamin D to ensure it had been prescribed in line with NICE guidance. The outcome of the audit demonstrated that vitamin D had been prescribed correctly with particular reference to prescribing for pregnant or breast feeding women and women with a low Body Mass Index (BMI).

The aim of the second audit was to measure the patient waiting time for one GP. As result of the audit it was established that the majority of patients waited for an average of eight minutes. It was noted that there had been an increase in new patient registrations and many of these patients had multiple medical problems. This had increased consultation times and led to a delay for waiting patients. As a result of the audit new patients were asked to complete a comprehensive medical form. Patients were then seen by the health care assistant for a new patient health check. This meant that the GP had good information on the health care needs of patients with multiple medical problems prior to their first appointment.

We reviewed the CCG printout of unscheduled attendances to the Accident and Emergency Department in March 2014 and June 2014. In March the practice was the second highest in the locality. Improvements were made by training reception staff, ensuring GPs worked more consistently and by the employment of the nurse practitioner. In June 2014 the practice had dropped to the fourth highest for attendance in the locality.

The practice had achieved 695.52 Quality and Outcomes Framework (QOF) points out of a target of 881 points for the year 2013/2014. QOF is the voluntary incentive scheme used to encourage high quality care, with indicators to measure how practices were caring for patients. This result was 18.8% below the Hounslow CCG average.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We looked at the training records of the whole staff team and saw that staff were up to date with basic life support, child protection, safeguarding adults and infection control. Training records indicated that staff had also received training in health and safety and information governance and the Mental Capacity Act. Staff told us the practice was supportive of on going training, and study leave was available for further training.

The two GPs had participated in an annual appraisal and been revalidated in 2014. (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).

Good

Are services effective?

(for example, treatment is effective)

GPs attended Hounslow Education and Training (HEAT) sessions five times a year. These were organised by Hounslow CCG and covered a different topic at each session. Some of the topics covered were safeguarding, the referral facilitation service and the recently introduced dietary service.

The practice nurse who was qualified as an advanced nurse practitioner informed us she worked at the practice for two sessions a week. She was a member of a number of practice nurse online forums and met weekly with her mentor who was also an advanced nurse practitioner within Hounslow CCG. As an independent nurse prescriber she worked in conjunction with the GPs at the practice regarding patient care and prescribing. The practice nurse was appraised annually by one of the GPs at the practice. Non clinical staff informed us that they met with the practice manager for their appraisal but this was informal. There was no formal record of annual appraisal for non clinical staff.

The practice had identified Monday and Friday as busy days when patient demand was high. An additional receptionist was on duty between 9:00 am and 5.30 pm on both of these days to cater for patient demand. The practice also had two receptionists on duty during busy periods in the morning, lunch time and mid-afternoon.

Working with colleagues and other services

Suitable systems were in place to communicate with other providers. All staff we spoke with were clear about their role and said the systems worked well. The practice participated in multidisciplinary meetings to discuss the needs of patients with complex health needs including those receiving end of life care.

Clinical staff met monthly to discuss patient care. The health visitor only attended clinical meetings when a patient's care needed to be reviewed. The practice informed us they met with district nurses to discuss the care of individual patients approximately once every six months. The practice highlighted a need for more regular meetings with the district nurses but said this was difficult due district nurse work schedules.

Clinical staff at the practice met monthly with clinical colleagues from the Hounslow CCG area. The meeting was attended by GPs, the community matron, district nurses and the consultant in elderly care. Practices were able to present a case study for discussion. Topics discussed ranged from integrated care planning for patients, to dementia care, falls and preventing unscheduled admissions to hospital.

GPs attended a monthly meeting held for GPs in the Feltham locality to discuss care planning, dementia and mental health. The meeting was attended by a consultant, the community matron and social services. The safeguarding lead for the practice usually attended these meetings.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to record and manage patients care. All staff were trained in how to use the system and had also received training on information governance.

The practice used electronic systems to communicate with other providers. For example, information was received every morning from the out of hour's provider. GPs then reviewed this information and update the patient record. Patients were contacted by their GP for a follow up appointment if this was required.

There was a system in place to monitor blood test results. These were received electronically by the GP who would then send an 'electronic task' to receptionists to invite the patient in for the results. Records evidenced that this was done on a daily basis.

Consent to care and treatment

Clinical staff were clear about requirements to seek consent prior to providing treatment. Staff had not completed formal training on the requirements of the Mental Capacity Act (2005) but were clear about their responsibilities. They were aware of when best interest decisions would be needed and how to ensure children were legally able to consent to treatment by demonstrating an understanding of Gillick competence.

Health promotion and prevention

Clinical staff demonstrated a good knowledge of the health needs of the local population and used this to determine health promotion.

There was a GP lead for the management of diabetes who was responsible for the management of type 2 diabetes

Good

Are services effective?

(for example, treatment is effective)

and insulin initiation. The practice nurse held clinics for diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD). The nurse offered spirometry testing which is a test used to diagnose lung conditions.

The healthcare assistant ran a Phlebotomy Clinic (to take bloods) and undertook health checks for new patients and patients aged forty years and over. The healthcare assistant offered advice on smoking cessation and patients could also be referred to the smoking cessation service which was held in the same building as the practice. The practice was open between 8:00am and 8:00pm during the working week and working patients unable to attend the practice were offered telephone appointments.

There was a range of information leaflets available at the practice for patients to help them understand their condition and improve their health. The practice website contained information about how to respond to a range of minor ailments. We were informed patients were sometimes signposted to the local library service on the ground floor of the building. Here they would find information on healthy lifestyles.

The practice had a higher number of registered female patients aged 23-34 years than the national average. Seventy three per cent of eligible patients in 2013/2014 had attended the practice for a smear test. The national average for smear test uptake stood at 89%. The practice informed us that smear testing was often declined due to cultural reasons. To assist patients in their understanding of this test, leaflets had been prepared in languages used in the local community.

The number of older patients registered with the practice was significantly lower than the England average for medical practices. Patients over the age of 75 had a named GP. The practice informed us that the prevalence of long term conditions was low. A summary of older patients care needs was held on their electronic record. All of the patients who were eligible were invited to the practice for their annual flu vaccine.

When patients registered there was a section on the form requesting information on caring responsibilities. If patients had the role of carer they could be referred to a carer support service.

Antenatal clinics were available daily which were run jointly between the lead GP and the practice nurse. The GP conducted the postnatal eight week check, the practice nurse then proceeded with the childhood immunisations. Childhood immunisation rates were in line with those of other practices within Hounslow CCG with some slight variation where the practice was either slightly over or under CCG bench mark percentages. The lead GP had a background in paediatric and childhood asthma care. Babies and children were referred by the other GPs at the practice to the lead for this care. Daily appointments and emergency telephone appointments were available for babies and children.

Sexual health and contraception advice was offered by both GPs. The female GP fitted contraceptive implants and intrauterine contraceptive device.

There was a transient population with a high proportion of patients who had recently moved into the area from Eastern Europe and Asia. We were informed that the practice was flexible when they registered people and they would consider registering people without proof of address if this enabled them to receive the healthcare they needed. Practice staff had an awareness of forced marriage within the community. Where it was noted that some female patients were always accompanied to their consultation by a relative, the GP would aim to see them on their own.

The practice staff spoke a number of languages including Arabic, Cantonese, Somali and Asian languages. Language line, a translation service, was used where this was needed.

Patients were referred to the Improving Access to Psychological Therapies Service for Cognitive Behavioural Therapy (CBT) and the management of stress and anxiety disorders. GPs requested that patients contact them if they had not heard from a service within three weeks of the referral date. Referrals were also made to a local drug and alcohol treatment team where patients had been assessed as requiring this service.

The practice worked with a local Hospital and a local Mental Health Trust for the assessment, treatment and care planning of patients with poor mental health. When patients were discharged from hospital we were informed by GPs their care plan was forwarded to the practice.

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 2014 national patient survey in which 21% of the patients surveyed gave feedback. According to the National Patient Survey 83% of respondents said the nurse they last spoke with gave them enough time during their consultation in comparison to the CCG average of 88%. Fifty-seven per cent of respondents said their GP treated them with care and concern, with the CCG average standing at 79%.

We received 17 patient comment cards from patients who visited the practice during the two weeks before our visit. Patients indicated they were satisfied with the service they received at the practice. They said that the surgery was clean, staff were professional and friendly and reception staff were helpful and efficient. Patients said staff were caring and treated them with dignity and respect.

Patients we spoke with said they were satisfied with the level of care they were receiving. One newly registered patient confirmed they had an appointment booked for their health check. A working patient said they were pleased with the online appointment booking system with text confirmation. We saw staff demonstrated good knowledge of patients, greeting them by name, speaking with them politely and respectfully.

The reception area in the practice was shared with other GP practices which meant conversations could be overheard. However, a room was available at the practice if a patient wished to have a private conversation with a member of staff. Curtains were provided in consultation rooms to provide privacy during examinations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with said they were involved in making decisions about the care and treatment they received; the doctors and nurses listened to them and took time to explain things to them in ways they understood. Out of the 17 comments cards one patient was not satisfied with the information they received from their GP.

There was a range of information leaflets about different long term health conditions and how to develop and maintain a healthy lifestyle in the waiting areas and on the practice website.

Patient/carer support to cope emotionally with care and treatment

The information we received from the patients we spoke with and the completed comment cards informed us that patients were supported by staff in their care and treatment. None of the patients we spoke with said they had needed additional support for bereavement. We spoke with staff who informed us that bereaved patients would be telephoned by a member of staff at the surgery and a letter of condolence sent to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice knew the needs of the local population and were responsive to those needs. Staff spoken with were aware of local services and support groups to refer patients to when required. The local population had a high proportion of patients who had recently moved into the area from Eastern Europe and Asia. Staff told us that where required they were able to refer patients to specialist services, for example to the Asian counselling service.

The GP and business manager attended regular meetings with the Clinical Commissioning Group (CCG), who, along with other practices looked at the improvements needed to meet local health needs.

A virtual Patient Participation Group (PPG) was in place. Ten patients were members of the PPG. Staff informed us that although meetings had been arranged in the past patients had not attended. Patients had been telephoned and asked for their views. The practice recognised the value of patient participation and was trying to recruit members through adverts in the waiting area and on the practice website.

Tackling inequity and promoting equality

GPs told us they provided health care services to everyone who attended. If a patient had difficulty with language or was unable to produce the correct documentation this did not prevent them from receiving the treatment they needed. Staff told us they had access to face to face and telephone interpreters when needed.

The electronic recording system had an indicator system to show if a patient was vulnerable and if a child was on a child protection plan.

Access to the service

The practice was open from 8.00am-8.00pm during the working week. At weekends patients were directed to an out of hours provider. The practice offered a range of book in advance and on the day emergency appointments for patients. GPs carried out home visits when they felt it was necessary. The named GP for patients over the age of 75 usually carried out home visits to older patients when this was required. Records viewed indicated that there had been18 home visits in the last six months. We were informed GPs had noticed that repeat prescriptions were being presented for older patients who had not been seen at the practice for a considerable length of time. Arrangements were then made for these patients to receive a home visit from their GP.

We looked at how appointments were managed on the electronic system and saw that colour-coded slots identified pre booked appointments, home visits, emergency appointments and telephone consultations. GP locums covered the telephone consultations. Patients with long term conditions, older patients and children were allocated same day appointments.

Sixty per cent of respondents to the National Patient Survey said it was easy to get through on the phone and 61% said they usually waited less than 20 minutes when they arrived for their appointment.

The practice had carried out an audit of patient waiting times. It was noted that although antenatal patients had twenty minute appointments they had been allocated ten minutes on the booking system and this had caused delays. In response to this booking times were changed to reflect the correct appointment lengths. At the time of the inspection this information had not been re-audited to measure the success of the changes.

The practice had responded to requests from new patients (particularly those newly arrived in the UK) for routine blood tests by changing their policy when patients registered. New patients were now offered an appointment with the healthcare assistant who offered them a blood test in addition to the new patient health check. Once completed the patient was seen by their GP with the relevant medical information. Staff informed us that as a result of the change patients needs were met and the practice could manage GP resources.

The practice had a system for managing missed appointments- 'did not attends' (DNAs). These were managed by writing to the patient and after three missed appointments, in a six months period, informing the patient they would be removed from the list. Children, patients with chronic diseases and vulnerable patients were exempt.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a compliments, comments and complaints leaflet for patients. This also gave information on how to contact external agencies such as Parliamentary Health Service Ombudsman (PHSO) and Independent Complaints Advocacy Service (ICAS).

The complaints procedure was displayed in reception and on the practice website. The practice manager was responsible for dealing with complaints. Records of complaints showed they had all been responded to. We looked at three complaints and saw that as a result of these checks and changes had been put in place for repeat prescribing.

Learning from complaints was shared with staff at practice meetings. The provider (The Practice Surgeries Limited) had a central system for recording and monitoring complaints. These governance systems were accessed by the team at head office which meant that complaints and the outcomes for patients were being monitored by the provider of the service.

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

We spoke with a range of staff and although the practice did not have a formal vision statement all of the staff knew the about the values of the practice, how to offer good patient care and what their responsibilities were in relation to these values.

Governance arrangements

There were clear governance arrangements and staff we spoke with were aware of the reporting structures. They told us managers were approachable and provided support to them when required. Staff had allocated lead areas of responsibility. For example there was a GP lead for safeguarding, treating patients with long term conditions and children's health care. All staff with lead responsibilities with whom we spoke were aware of their roles and responsibilities.

The practice had policies and procedures in place and they were all available on a shared drive so all staff could access them. There was a business continuity plan in place which took account of potential disruptions to the service.

Leadership, openness and transparency

Leadership structures were clear and there was an open and transparent environment. The practice manager was responsible for the day to day running of the practice from the business side and the two GPs led in different areas of patient care. Staff were aware of these structures and those in leadership positions. Staff told us they were supported to carry out their duties and that management were approachable. Reception staff said that they were always updated about developments in the surgery. Reception staff said although it was not always possible for them to attend meetings due to their differing shift patterns (as some receptionists worked in the evening) the practice manager had an open door policy and was available.

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

The practice gathered feedback from patients through National patient surveys, the practice email, NHS Choices and complaints received.

The practice had a Patient Participation Group (PPG) but regular meetings were not taking place. Individual views were sought by telephone however these had not been collated or analysed. Although patient surveys had not been carried out by either the PPG or the practice, patient feedback from the National Patient Survey had been analysed. An action plan was in place to address areas for improvement.

Management lead through learning and improvement

Staff were supported to learn and develop on a continual basis. Training and development opportunities were available and each member of staff had a training record. The GPs and the practice nurse had a formal appraisal which was recorded; however there was no formal appraisal for reception staff.

Clinical staff attended regular meetings at the practice to review patient care. Clinicians also attended monthly meetings with other health and social care professionals and peers within the Hounslow and Brentford locality. This was to ensure they worked together in problem solving and to improve performance, and improve outcomes for patients.