The Willow Tree Surgery

Quality Report

2 Jollys Lane
Hayes
Middlesex
UB4 9BG
Tel: 020 8842 1024
Website: www.willowtreesurgery.co.uk

Date of inspection visit: 19 December 2017
Date of publication: 05/02/2018

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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at The Willow Tree Surgery on 19 December 2017. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The new provider had not been inspected before and that was why we included them.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. However, there were weaknesses in monitoring uncollected repeat prescriptions and the practice's business continuity plan.
- When incidents did happen, the practice learned from them and improved their processes. However, we noted the documenting of significant events lacked detail of the lessons learned and follow-up of the event.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines. However, the coding of exception reporting and the prevalence of long term conditions was not accurate.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.

Summary of findings

- There was a focus on continuous learning and improvement at all levels of the organisation. Although we found the practice's vision and strategy had not been shared with staff.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Review the process for recording significant events.
- Review the system for checking uncollected repeat prescriptions.
- Review the business continuity plan.
- Continue to review patient satisfaction with the availability and punctuality of appointments.
- Share the practice's vision and strategy with staff.

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

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
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

The Willow Tree Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser.

Background to The Willow Tree Surgery

The Willow Tree Surgery is a single handed GP practice located in Hayes, Middlesex. The practice is part of NHS Hillingdon Clinical Commissioning Group (CCG) and provides primary medical services to approximately 3,600 patients.

Services are provided from:

- 2 Jollys Lane, Hayes, Middlesex UB4 9BG

Online services can be accessed from the practice website:

- www.willowtreesurgery.co.uk

The practice is led by a GP principal (female) who is supported by a regular GP locum (male). The GPs collectively provide 11.5 sessions per week. Other staff include a practice nurse (38 hours); a practice manager (37hours); and six receptionists / administrators.

The practice operates from a single storey building with wheelchair access. There are three consultations rooms, a waiting room, and administrative areas.

The practice doors are open from 8:00 to 18:00 and the phone lines from 8:00 to 18:30 every weekday. Extended hour appointments are available from 7:00 to 8:00 on Monday and Tuesday morning. When the practice is closed patients are directed to the out of hours service or can be booked an appointment with the local primary care hub.

The practice has a lower percentage of patients over 65 years of age when compared to the national average. The practice population is ethnically diverse with 43% white, 33% Asian, 14% black, 5% mixed race and 5% from other ethnic groups. The practice area is rated in the fourth deprivation decile (one is most deprived, ten is least deprived) of the Index of Multiple Deprivation (IMD). People living in more deprived areas tend to have greater need for health services.

The practice is registered with the Care Quality Commission to provide the regulated activities of: diagnostic & screening procedures; family planning; maternity & midwifery services; and treatment of disease disorder & Injury.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. The practice had advertised for salaried GPs but were unsuccessful and currently relied on GP locums to cover sessions when required.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. The practice did not have a paediatric pulse oximeter. Following our inspection they provided evidence that this device had been purchased.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had some systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Emergency medicines were stored securely and regularly checked to ensure they were safe to use. However, the risks of not stocking certain emergency medicines had not been assessed. During our inspection we saw evidence that the practice had ordered these additional emergency medicines.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal

requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines. Repeat prescriptions were signed before being dispensed to patients and there was a process to ensure this occurred. However there was no system to ensure prescriptions were collected in a timely manner, particularly for vulnerable patients and those with complex health needs. Following our inspection the practice told us they would develop a system to check and follow-up uncollected prescriptions, particularly for children and patients with a learning disability or mental health problem. Any concerns would be escalated to a clinician.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The practice had a business continuity plan for major incidents such as power failure or building damage. However, the plan did not include emergency contact numbers for staff. Staff were given a wallet card that contained telephone numbers for all staff at the practice. Following our inspection the practice sent us their updated business continuity plan which contained contact numbers for suppliers such as the gas and electricity company.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. The GP principal and practice manager supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. Staff gave examples of how the practice learned, shared lessons, and took action to improve safety in the practice. However, we found the documenting of significant events on the practice's template lacked detail of the lessons learned and follow-up of the event.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing effective services.

The practice was rated as requires improvement for providing effective services because:

- Clinical exception reporting for some long-term conditions was high.
- Uptake rates for childhood immunisations and cervical screening were low.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

We reviewed prescribing data and found the practice performed in line with local and national averages. For example:

- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group was 0.83 (CCG - 0.7; national average – 0.9). Hypnotics, more commonly known as sleeping pills, are a class of psychoactive drugs whose primary function is to induce sleep and to be used in the treatment of insomnia, or surgical anaesthesia. Hypnotics should be used in the lowest dose possible, for the shortest duration possible and in strict accordance with their licensed indications.
- The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 0.8 (CCG – 0.92; national average 0.98).
- The number of antibiotic items (Cephalosporins or Quinolones) prescribed was 4% which was comparable to local (5%) and national averages (5%). The practice demonstrated awareness to help prevent the development of current and future bacterial resistance. Clinical staff and prescribing data evidenced the practice prescribed antibiotics according to the principles of antimicrobial stewardship, such as prescribing antibiotics only when they are needed (and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats) and reviewing the continued need for them.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice worked with multidisciplinary teams to discuss older patients with complex conditions, and those who may need palliative care as they were approaching the end of life.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, the nurse had undergone additional training in family planning and asthma.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients with long-term conditions (QOF is a system intended to improve the quality of general practice and reward good practice). Performance for conditions such asthma, COPD, diabetes, hypertension, and atrial fibrillation was in line with local and national averages. For example, the percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months was 81% (CCG 77%; national 76%). Exception reporting for this indicator was 6% (CCG 3%; national 8%).

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice was also taking part in a programme that provided patients with diabetes an action pack, which included weighing scales, a phone application and a diet plan, to improve the management of their condition.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to under two year olds averaged 75% which was below the target percentage of 90%. Unpublished and unverified practice data showed uptake rates for 2016/17 had improved slightly and averaged 77%. The practice told us they aimed to improve uptake rates by appointing a member of staff who would work with the practice nurse to manage recalls and follow up patients due for immunisations.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice could refer children to the community paediatric service. If appropriate, patients would be seen by a paediatrician in one of the local Clover Health network of practices.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 67%, which was below the 80% coverage target for the national screening programme.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and carers.

People experiencing poor mental health (including people with dementia):

- The practice provided care to patients with dementia in a local care home. These patients were visited by the guided care matron every week and any concerns were escalated to the GP. The GP principal also carried out an annual health check and medication review for these patients.
- Seventy five percent of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable to the CCG and national averages of 83% and 84% respectively.
- One hundred percent of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was better than the CCG and national average of 92% and 90% respectively.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 100%; CCG 93%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 98%; CCG 96%; national 95%).

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, we saw a completed clinical audit for antibiotic prescribing.

The most recent published Quality Outcome Framework (QOF) results were 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The clinical exception reporting rate was 23% compared with the CCG average of 9% and a national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) Exception reporting was high for the following conditions: coronary heart disease (practice 16%; CCG and national 9%); asthma (practice 12%; CCG 3%; national 6%); chronic obstructive pulmonary disease (practice 43%; CCG 12%; national 13%); diabetes mellitus (practice 29%; CCG 10%; national 11%); depression (practice 29%; CCG 24%;

Requires improvement

Are services effective?

(for example, treatment is effective)

national 23%); and mental health (practice 20%; CCG 10%; national 11%). The practice was aware that their published exception reporting was high and the prevalence reporting for some conditions low. They told us these figures were inaccurate and were a result of historic issues they had inherited from the previous provider in 2014. The GP principal and practice manager were trying to address these by reviewing patient records and updating exception reporting errors. An analysis of the practice's coding had also been carried out by their local network, Clover Health Ltd. The report highlighted discrepancies with coding of prevalence for certain conditions. The practice was working through the lists identified in the report to address this.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Thirty of the 33 patient Care Quality Commission comment cards we received were positive about the service experienced. This was in line with other feedback received by the practice. Three partially positive comments referred to difficulties booking an appointment and staff attitude.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and twenty four surveys were sent out and 113 were returned. This represented about 3% of the practice population. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 83% of patients who responded said the GP gave them enough time; CCG - 85%; national average - 86%.
- 93% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 83% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG – 85%; national average - 86%.
- 95% of patients who responded said the nurse was good at listening to them; CCG - 92%; national average - 91%.
- 97% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 92% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 89% of patients who responded said they found the receptionists at the practice helpful; CCG - 87%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard:

- Interpretation services were available for patients who did not have English as a first language. A notice at reception informed patients this service was available. Patients were told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. This was done at registration and during consultations. A carer's protocol was available to assist staff in identifying carers and the support they may require. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 48 patients as carers (1.3% of the practice list).

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. Carers were invited for health checks and the flu vaccine.
- Information in the waiting room directed carers to the various avenues of support available to them.
- Staff told us that if families had experienced bereavement, their usual GP contacted them. This was either followed by a patient consultation at a flexible time to meet the family's needs or by giving them advice on how to find a support service.

Good

Are services caring?

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 86% and the national average of 86%.
- 81% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 80%; national average - 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 89% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 85%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours on Monday and Tuesday morning, online services such as repeat prescription requests, advanced booking of appointments, and advice services for common ailments.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. They also made arrangements with local pharmacies to deliver medicines to housebound patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held monthly multidisciplinary team meetings to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Children were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours on Monday and Tuesday from 07:00 to 08:00, and ad-hoc Saturday appointments for the seasonal flu vaccination.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice could remotely book evening and weekend GP and nurse appointments for patients willing to attend a local primary care 'hub'.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability, patients who were housebound, and those who were at high risk due to their conditions.
- Patients with a learning disability were offered longer appointments and annual health checks.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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

Are services responsive to people's needs?

(for example, to feedback?)

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients with mental health conditions were offered longer appointments and annual health checks.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients with mental health conditions could be referred to a community psychiatric nurse who attended the practice every week.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages, with the exception of the waiting time to be seen. This was supported by observations on the day of inspection and completed comment cards.

- 80% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 59% of patients who responded said they could get through easily to the practice by phone; CCG – 64%; national average - 71%.
- 84% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 87%; national average - 84%.
- 82% of patients who responded said their last appointment was convenient; CCG - 82%; national average - 81%.
- 71% of patients who responded described their experience of making an appointment as good; CCG - 69%; national average - 73%.
- 39% of patients who responded said they don't normally have to wait too long to be seen; CCG - 53%; national average - 58%.

The practice carried out a survey in July 2017 to continually improve the service. Fifty surveys were distributed to patients and 28 responses were received. Respondents did not highlight concerns with waiting times. For example, 22 out of 28 patients described the waiting time to be seen as 'very good' and five patients said it was 'fair'.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Four complaints were received in the last year. We reviewed a complaint and found that this was satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. For example, reception staff had undergone training in customer care, conflict resolution, and complaints to improve their interactions with patients.

Are services well-led?

Good

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The GP principal took over the practice as a sole provider in June 2014. The assistant practice manager started in October 2014 and was appointed practice manager in February 2015. The leadership team told us they faced many challenges when taking over the practice as a result of the previous provider. For example, there was a backlog of documents to be scanned, clinical workflow was not cleared daily, the computer system was not used to its full potential, there was a lack of communication within the practice and externally and there was low staff morale. The GP principal and practice manager had addressed these issues to improve the management of the practice.
- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and strategy for the practice, however this had not been shared with all staff.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, patients were kept updated on the progress and outcome of incidents. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were clear responsibilities, roles and systems of accountability.

- The governance and management of joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

Are services well-led?

Good

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

There were processes for managing risks, issues and performance. However, there were weaknesses in some governance systems.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. However, there were systemic weaknesses in governance systems relating to significant events, uncollected repeat prescriptions and business continuity.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information. However, there were errors in the coding of some data.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account. However, the information used to monitor performance and the delivery of quality care was not accurate. For example, exception reporting for some long-term conditions was high and the practice had coding discrepancies which contributed to data showing a low prevalence of certain long-term conditions. The practice disputed the accuracy of this data and had plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the practice had 50% of appointments bookable on the day for routine and emergency appointments as a result of patient feedback,
- The practice were in the process of setting up a patient participation group and had currently recruited three members.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example, two non-clinical staff had expressed an interest in phlebotomy training and the practice were looking into courses for them.
- The practice was part of the Clover Health Ltd network which was a group of 15 practices within Hayes and Harlington. They worked collaboratively to deliver clinical care and conducted regular analyses of the practices to ensure they were performing in accordance with local and national guidelines. The GP principal was currently a chief financial officer for the network.
- The GP principal and nurse were involved in the training of physician associates and student nurses.
- Following the implementation of a system to streamline clinical correspondence within the practice, the practice manager was involved in a local project aimed at

Are services well-led?

Good

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

creating a best practice process for managing electronic information. This involved working with selected GP practices to share learning and presenting the information to the wider CCG.

- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person had systems or processes in place that were operating ineffectively. In particular: • The registered person had failed to ensure the care and treatment of service users met their needs. Outcomes for patients with long term conditions, people experiencing poor mental health, cervical smears and childhood immunisations were below local and national averages. This was in breach of Regulation 17(1) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.