

Cuckoo Lane Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Cuckoo Lane Practice on 28 January 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for being well-led and providing responsive and effective services. We found they were good for providing safe and caring services. It was also outstanding for the care provided to older people, people with long term conditions, families, children and young people, people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia). They were good for the care and treatment they offered working aged people (including those recently retired) and people whose circumstances make them vulnerable.

Our key findings were as follows:

- Arrangements were in place to ensure patients were kept safe. The practice learnt when things went wrong and shared learning with all staff to minimise the risk of reoccurrence

- Patients' needs were appropriately assessed and care and treatment was delivered in line with current legislation and best practice.
- We saw from our observations and heard from patients that they were treated with dignity and respect.
- The practice understood the needs of their patients and provided services that met their needs.
- The practice was well-led, had a defined leadership structure and staff felt supported in their roles.

We saw areas of outstanding practice including:

- One nurse practitioner at the practice carried out spirometry tests and also provided a weekly clinic for patients registered at other local practices. All COPD patients are given a self-management plan with particular reference to rescue medication. This has led improved symptom control and less hospital admissions for 25% of patients in this group over the last year.
- The practice took part in the 'shifting settings of care' program which supported patients with mental illness access better, more integrated care outside of hospital

Summary of findings

and transfer the care of people with 'common mental illness' or stable 'severe and enduring mental illness' from mental health services into primary care. One impact being 19 patients who would have previously received care in Secondary care setting in the past are now receiving their support and treatment from their GP surgery.

- An example of integrated care for older people is that an Age UK support worker attended the practice three days a week, to support older patients who live on their own. The practice also provided transport to improve access for those patients who are house

bound or find it difficult to get to the surgery. Patients reported satisfaction and liked being able to attend the surgery. This improves socialisation and reduced the amount of home visits by 20 during its first month.

- The practice was instrumental in establishing an Ealing wide approach to the three tier model of shared care for diabetes. This pilot project was part of a major redesign of diabetes care across Ealing and led to more diabetic nurse specialist being appointed including a Diabetic nurse consultant for the borough and weekly satellite clinics.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed and staff told us there were enough staff to keep people safe. A slot for significant events was on the monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out annually. All staff had received child protection and adult safeguarding training. Appropriate recruitment checks had been undertaken prior to employment for all staff which included checks with the Disclosure and Barring Service (DBS). The infection control lead had carried out audits during the last year and improvements that had been identified for action were completed on time.

Good



Are services effective?

The practice is rated as outstanding for effective. Data showed patient outcomes were at or above average for the locality. The practice had developed clinical templates so that the links to NICE and other bodies were embedded in the templates. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's capacity to make decisions and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had carried out staff appraisals and had established personal development plans for all staff. There was evidence of multidisciplinary working to discuss the needs of complex patients especially those with care plans. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Outstanding



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others in the borough for several aspects of care. Patients said they were treated with compassion, dignity and

Good



Summary of findings

respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Patients who had care plans had annual reviews or more frequently where needed.

We saw that staff treated patients with kindness and compassion ensuring confidentiality was maintained. Patients told us the care was excellent and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback from the CQC patient comment cards we received was also positive and aligned with these views. Clinicians told us they would make phone calls to families who had suffered bereavement and offer to refer them to appropriate services for support.

Are services responsive to people's needs?

The practice is rated as outstanding for responsive. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The practice used a risk stratification tool designed to identify patients at highest risk of attending A&E or being admitted to hospital, and also to enable the GPs to have peer to peer discussions regarding patients with similar health concerns. One nurse practitioner at the practice carried out spirometry tests and liaised regularly with the GP that managed the care of patients diagnosed with chronic obstructive pulmonary disease (COPD). They also provided a weekly clinic for patients registered at other local practices.

The practice took part in the 'shifting settings of care' program which supported patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. A mental health worker, employed by the CCG, would attend the practice every two weeks to meet with people recently discharged from hospital. An Age UK support worker attended the practice three days a week, to support older patients who live on their own. They also provided transport to improve access for those patients who are house bound or find it difficult to get to the surgery. The practice also registered patients who had 'no fixed abode' such as travellers and homeless people.

Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders. The practice reviewed

Outstanding



Summary of findings

complaints on an annual basis to identify any themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. The practice used a telephone translation service and the automated checking in machine located in the waiting room was in five different languages. The premises were accessible to patients with disabilities, for example there was street level access to the practice, lift access to the first floor and the toilets were accessible to wheelchair users.

Are services well-led?

The practice is rated as outstanding for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. The practice proactively sought feedback from staff and patients and this had been acted upon. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice had an active patient participation group (PPG) and we saw that they discussed issues such as electronic prescriptions, practice/patient communication, patient survey and the re-launch of the group. Staff had received inductions, annual performance appraisals and attended staff meetings and events.

Outstanding



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

Patients over 75 years had a named GP to co-ordinate their care. The named GP held regular meetings with other health care professionals to provide multidisciplinary care for older patients and liaised with appropriate health care professionals when required to ensure older patients received effective care. The practice had a list of older people who were housebound whom they would visit regularly, particularly frail older patients. They used a risk stratification tool designed to identify patients at highest risk of attending A&E or being admitted to hospital, and also to enable the GPs to have peer to peer discussions regarding patients with similar health concerns

An Age UK support worker attended the practice three days a week, to support older patients who live on their own. Their role included befriending, attended patients' homes to carry out small repairs like replacing light bulbs and changing plugs, liaising with social services and acting as advocates. The practice also provided transport to improve access for those patients who are house bound or find it difficult to get to the surgery. Patients report satisfaction and report liking being able to attend the surgery. This improves socialisation and reduced the amount of home visits by 20 during its first month.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families

Outstanding



People with long term conditions

The practice is rated as outstanding for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this population group that had a sudden deterioration in health. Where needed, longer appointments and home visits were available. Patients with a long term condition had a named clinician, a care plan and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named clinician worked with relevant health and care professionals to deliver a multidisciplinary package of care. Nursing staff had received appropriate training to manage and support patients with long term conditions such as spirometry. The practice had GP leads for a variety of chronic conditions including diabetes, chronic obstructive pulmonary disease (COPD) and asthma. The practice carried out spirometry tests and liaised regularly with the respiratory

Outstanding



Summary of findings

consultant that managed the care of patients diagnosed with chronic obstructive pulmonary disease (COPD). They also provided a weekly clinic for patients registered at other local practices. The practice was instrumental in setting up an Ealing wide approach to the three tier model of shared care for diabetes. We saw the practice had scored 100% of their QOF target in most of the long term conditions indicators.

Families, children and young people

The practice is rated as outstanding for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk such as children subject to child protection plans. The safeguarding lead attended child protection case conferences and reviews where appropriate and reports were sent if staff were unable to attend. There were weekly immunisation baby clinics and immunisation rates were high in comparison to other practices in the CCG, for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. The clinicians offered family planning advice, fitted IUDs and prescribed the contraceptive pill

Outstanding



Working age people (including those recently retired and students)

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. They had extended opening for one hour one day a week, offered phone consultations and online services for ordering repeat prescriptions, booking appointments and getting test results were available. The practice offered a full range of health promotion information and invited patients over 40 years of age to have an NHS health check.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. There was a system to highlight vulnerable patients on the practice's

Good



Summary of findings

electronic patient records. The practice had carried out annual health checks for people with learning disabilities and 95% of these patients had received health checks last year. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

The practice used a telephone translation service and the automated checking in machine located in the waiting room was in five different languages.

People experiencing poor mental health (including people with dementia)

The practice took part in the 'shifting settings of care' program which supported patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. A mental health worker, employed by the secondary care trust, would attend the practice every two weeks to meet with people recently discharged from hospital. The support offered was holistic which included information and advice about housing, income, social and general health. One impact being 19 patients who would have previously received care in Secondary care setting in the past are now receiving their support and treatment in their GP surgery.

The GP's also had access to consultant psychiatrists help line at Ealing hospital where they would discuss concerns such as medication swaps and co-morbidities. Patients who experienced poor mental health were kept on a register and invited for annual reviews with extended appointments. Reception staff we spoke with were aware of signs to recognise for patients in crisis and to have them urgently assessed by a GP if they presented at the practice. The practice scored 100% of their QOF target for dementia

Outstanding



Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection and received 26 completed Care Quality

Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were very positive about the practice

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and

non-clinical staff. Most of the patients we spoke with had been registered with the practice for many years and told us staff were friendly, efficient and understanding and the GPs gave consistently good care. This was similar to the findings of the latest national GP patient survey which found that 90% of respondents described their overall experience of the practice as good and 78% said that they would recommend the practice to someone new.

Outstanding practice

- One nurse practitioner at the practice carried out spirometry tests and also provided a weekly clinic for patients registered at other local practices. All COPD patients are given a self-management plan with particular reference to rescue medication. This has led to improved symptom control and less hospital admissions for 25% of patients in this group over the last year.
- The practice took part in the 'shifting settings of care' program which supported patients with mental illness to access better, more integrated care outside of hospital and transfer the care of people with 'common mental illness' or stable 'severe and enduring mental illness' from mental health services into primary care. One impact being 19 patients who would have previously received care in Secondary care setting in the past are now receiving their support and treatment from their GP surgery.
- An example of integrated care for older people is that an Age UK support worker attended the practice three days a week, to support older patients who live on their own. The practice also provided transport to improve access for those patients who are house bound or find it difficult to get to the surgery. Patients reported satisfaction and liked being able to attend the surgery. This improves socialisation and reduces the amount of home visits by 20 during its first month.
- The practice was instrumental in establishing an Ealing wide approach to the three tier model of shared care for diabetes. This pilot project was part of a major redesign of diabetes care across Ealing and led to more diabetic nurse specialists being appointed including a Diabetic nurse consultant for the borough and weekly satellite clinics.

Cuckoo Lane Practice

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 second inspector, GP and an expert by experience who were granted the same authority to enter the practice premises as the CQC inspectors.

Background to Cuckoo Lane Practice

Cuckoo Lane Practice provides GP primary care services to approximately 4,400 people living in the London Borough of Ealing. The practice is owned by two nurse practitioners, who are the partners and as such holds an Alternative Provider Medical Services (APMS) contract and was commissioned by NHSE London. It is staffed by three salaried GPs, two males and one female who work part time hours. There are five nurse practitioners, four nurses, a healthcare assistant, a pharmacist, a practice manager and seven administrative staff. The practice was registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are 8am to 6.30pm Mondays, Tuesday, Wednesday and Fridays and 8am to 8pm on Thursday. The 'out of hours' services were provided by an alternative provider. The details of the 'out of hours' service were communicated in a recorded message accessed by calling the practice when it was closed and details could also be found on the practice website. The practice provided a wide range of services including clinics for

asthma, chronic obstructive pulmonary disease (COPD), contraception and child health care. The practice also provided health promotion services including a flu vaccination programme and cervical screening.

Ealing is the third largest of London's 32 boroughs in terms of population. It has more people of working age than the UK as a whole, and fewer older people. Ealing has a very mobile population and evidence from patient registrations at GP practices consistently show Ealing to have a high level of international migration. The borough of Ealing is ethnically diverse. In the latest census 49% gave their ethnicity as white, 30% as Asian, 11% as Black and 4.5% as of mixed or multiple ethnicities, the remainder identifying as Arab or other ethnicity. This is similar to the practice patient population which is 50% white British, 15% white, 20% Asian and 15% Black. Ealing records a high deprivation score relative to the London average and has the 17th highest level of child poverty in London (out of the 32 boroughs in the capital). In addition, inequalities in skills and income levels causes social polarisation to exist within the borough.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

We 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 28 January 2015. During our visit we spoke with a range of staff (doctors, nurse, senior administrator and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. They had processes in place for documenting and discussing reported incidents and national patient safety alerts as well as comments and complaints received from patients. Administrative staff and receptionists were encouraged to log any significant event or incident and we saw there were two templates, one for administrative incidents and one for clinical incidents. Staff we spoke with were aware of their responsibilities to bring them to the attention of the practice manager. These were usually discussed on the day they occurred at one of the daily 'huddle meetings' which was attended by all staff on site. Action points were then circulated immediately to all staff. For example we saw that there had been a recent incident where a car was on fire next to the building which meant the building needed to be evacuated. We saw that the issues raised by the event was immediately discussed and documented. One key issue identified was the need to purchase an evacuation chair to assist disabled patients to evacuate the building. The chair was ordered immediately.

We reviewed safety records, incident reports and minutes of meetings from March 2014 where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw evidence to confirm that the practice completed a significant event analysis (SEA) annually which included identifying any learning from the incident. For example, we saw learning points from the above incidents included the need to nominate a lead to coordinate the event so that one person takes control for the evacuation of the whole health centre and a need to know who is in the building, both patients and staff. Reflection on positive points from the event included the event was managed in a professional way, the emergency button worked well, all staff and patients left speedily and each area took responsibility for their own patients/clients.

National patient safety alerts were disseminated by the practice manager to the relevant practice staff by email

through the practice's computer system messaging facility. Staff we spoke with told us of recent alerts they had discussed regarding preventing healthcare associated infections.

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 children. Clinicians were trained to level three and non-clinical staff were trained to level two. All staff had received training in safeguarding vulnerable adults.

The practice had up to date child protection and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were displayed on the walls in the general office and the GP consulting rooms and were easily accessible on the intranet.

The practice had a dedicated lead in safeguarding vulnerable adults and children which was one of the nurse practitioners. They could demonstrate that they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic patient records. This included information so that staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We saw an example of recent concerns about a child, whereby the main carer was unable to care for the child for a period of time and an alert was put in the records to contact the health visitor if the child was not brought in for their immunisations. The safeguarding lead was aware of vulnerable children and adults, and records demonstrated

Are services safe?

good liaison with partner agencies such as social services and health visitors. The safeguarding lead attended child protection case conferences and reviews where appropriate and reports were sent if staff were unable to attend.

A chaperone policy was in place and notices were visible on the waiting room noticeboard and in consulting rooms. We were told only nursing staff acted as chaperones and staff we spoke with understood their responsibility when acting as chaperones. All were DBS checked. We saw from clinical meetings minutes that the practice had recently amended the consent template to include chaperoning. The discussion had also reminded clinical staff to always ask patients about chaperones and document their response in their records.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

Medicines were stored in medicine refrigerators in one of the nurse's treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge.

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.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. A review of records supported this. There was a pharmacist based at the practice daily for one hour and they were responsible for generating repeat prescriptions. All prescriptions were reviewed and signed by a GP or nurse practitioner before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the

practice and kept securely at all times. The nurse practitioners and GPs reviewed medication for patients on an annual basis or more frequently if necessary. Vaccines were administered by the practice nurses using Patient group directions. We saw copies of some of these directions.

GPs reviewed their prescribing practices as and when medication alerts were received. We saw that GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings, for example the prescribing of NSAIDs. All clinical staff we spoke with discussed the clinical meetings and how these provided them with the opportunity to keep abreast of updated medication information.

The practice did not keep controlled drugs on site.

Cleanliness and infection control

We observed the premises were clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw cleaning was carried out by a contracted firm and cleaning records were kept which showed that most areas in the practice were cleaned daily, and the toilets were checked regularly throughout the day and cleaned when needed.

The practice carried out infection control audits, the last one was carried out in October 2014 and that actions were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

There were arrangements in place for the segregation of clinical waste. Colour coded bags were in use to ensure the safe management of healthcare waste and an external waste management company provided waste collection services. Sharps containers were available in all consulting and treatment rooms for the safe disposal of needles and sharp items. Clinical waste including sharps were stored in appropriate containers in a locked store room until collection by the waste management company. The practice had disposable personal protective equipment in place in all treatment rooms, including masks, aprons and gloves. Spillage kits were available for dealing safely with spills of bodily fluids.

One nurse practitioner was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and

Are services safe?

carry out staff training. All staff received induction training on infection control specific to their role and received annual updates. An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff told us they would always wear gloves to accept specimens from patients as stated in the infection control policy.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed that the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers which showed tests had been carried out in August 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, nebulisers, spirometer and weighing scales.

Staffing and recruitment

The practice had a recruitment policy in place which was up-to-date. Appropriate pre-employment checks were completed for staff before they started work at the practice. We looked at a sample of recruitment files for GPs, administrative staff and nurses and found they contained proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. There were procedures to follow in the event of staff absence to ensure smooth running of the service.

The partners and practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

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 which staff were required to read as part of their induction which was accessible on the intranet for all staff. One of the nurse practitioners at the practice was the identified health and safety lead and staff we spoke with knew who this was.

Identified risks were included on a risk matrix maintained by the practice manager and graded risks as low, moderate and high. Each risk was assessed, graded and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at practice meetings. For example, we saw they had discussed that some chairs in the waiting room were falling apart. It was agreed to remove the chairs and replace as soon as possible.

The practice used ratings in relation to the risk stratification tool assessments to identify patients at highest risk of attending A&E or being admitted to hospital. These were reviewed on a monthly basis. Staff were therefore able to identify and respond to changing risks to patients including deteriorating health. For example, the practice kept a register of vulnerable patients and the top 2% of their most vulnerable had alerts on their records so that they were prioritised when they contacted the practice. Staff would also follow up on attendance and results when patients in this group were referred for tests and medical procedures. This ensured they were able to inform GP's when patients had not attended for tests.

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed all staff were up to date in basic life support training. The practice had an easily accessible resuscitation trolley equipped with defibrillator, oxygen and airway devices. Emergency medicines were stored with the resuscitation equipment and included medicines for management of cardiac arrest, anaphylaxis, chest pain, seizures and asthma attacks. All emergency medicines were in date and expiry dates were checked weekly by the practice nurse.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This covered areas such as long or short term

loss of the main premises, loss of the computer system/essential data, loss of the telephone system, incapacity of GPs, flu pandemic and weather conditions. The document also contained relevant contact details for staff to refer to. For example, contact details of the site manager for the owners of the building, all staff contact numbers and email addresses and contact details for locum doctors. The plan was reviewed every year.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw this was reviewed after the recent car fire incident. We saw records to confirm the alarm had been tested regularly. Training records confirmed that staff were up to date with fire training.



Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided care in line with national guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw the practice had direct computer links to NICE and other guidelines and clinicians told us they found this much more practical and allows clinicians to access up to date evidence based care in a timely fashion. The practice also developed clinical templates so that the links to NICE and other bodies were embedded in the templates. This was replicated with their referral templates where guidance regarding a particular pathway were embedded into both the template and referral letter. We saw the practice had monthly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The GPs and nurses told us they completed thorough assessments of patients' needs and these were reviewed when appropriate in line with NICE guidelines.

There were leads for all specialist clinical areas such as chronic obstructive pulmonary disease (COPD) palliative care, diabetes and asthma. The nurse practitioners who were the leads for diabetes and COPD had completed additional specialist training courses in regards to managing patients with these conditions and weekly clinics were held for the practice patients. The COPD nurse also provided an extra service for Ealing CCG for people who were not registered with the practice, once a week and the diabetic nurse regularly met with the community diabetic specialist nurse. We saw quality and outcomes framework (QOF) scores for diabetes management and COPD for 2013/14 was 100%.

GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. Review of the clinical meeting minutes confirmed that this occurred at least once a month. For example, the practice had recently received a guideline on management of people with prostate conditions and the practice had identified where improvement can be made to how they respond and manage patients in this group.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We saw that where a clinician had concerns they would 'instant message' another clinician to get a second opinion.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes, which was approximately five percent of the practice patients. They had a complex cases action log which was reviewed at the weekly clinical meetings. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be contacted within 48 hours of them receiving notification. Discharge summaries were sent to the practice manager who would liaise with the relevant clinician to book an appointment, either at the surgery or the patients' home.

We saw the practice had carried out a review of their referrals to secondary care in April 2014, where they looked at referrals that were rejected. As a result the practice developed a double check system where a second clinician would look at referrals before they were actioned.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with all staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. Patients told us they had never experienced any discrimination at the practice.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice showed us six clinical audits that had been undertaken in the last year. Two of these were completed audits, meaning the practice had re-audited. The practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of patients with chronic asthma who had received an annual assessment. On the first audit the percentage of patients who had a medication review and annual review was 51%. After intervention, on re-audit the percentage attendance had increased to 68%. This was a full cycle audit which showed positive outcomes for patients. The practice told us that although they had made improvement they would continue to use a number of different approaches to



Are services effective?

(for example, treatment is effective)

further improve the numbers including setting up systems for people to complete online questionnaires, which depending on the results, would trigger a phone call or face to face consultation.

The clinicians told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. QOF is a national performance measurement tool. For example we saw an audit regarding patients taking diclofenac (anti-inflammatory painkiller) following a medicines management alert about prescribing non-steroidal anti-inflammatory drugs (NSAIDs). The practice reviewed all patients using this medication and showed us data evidencing a decrease in the numbers of prescriptions for most patients which lowered the risk of interactions.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the practice had scored 100% in all QOF areas except for learning disabilities. In 2013/14 there were discrepancies regarding the register that have now been addressed and they are currently on 100%. They had an identified learning disability lead and had an action plan which included ensuring all patients with a learning disability had up to date care plans and had been contacted to attend the practice for their annual health check.

Clinicians told us they were committed to maintaining and improving outcomes for patients.

The QOF report from 2012-2013 showed the practice was supporting patients well scoring 995.5 out of 1000. QOF information for 2013-2014 indicated the practice had maintained this level of achievement scoring 896 out of 900.

The team was making use of clinical audit tools and clinical meetings to improve performance. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also

checked that all routine health checks were completed for long-term conditions such as COPD and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, recorded the reason why they decided this was necessary. The evidence we saw confirmed that all clinicians had a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also attended a monthly federation meeting which was local benchmarking group run by the CCG. Performance data from the practice was evaluated and compared to similar surgeries in the area.

Effective staffing

The practice staff team included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and defibrillator training. A good skill mix was noted amongst the doctors and nurse practitioners. Both GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated in 2014. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

The staff induction programme covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics. Staff also had access to additional training to ensure they had the knowledge and skills required to carry out their roles. For example, reception staff told us they had received



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information technology training, in relation to the patient's database and the practice manager had attended and completed the level 5 Diploma in Primary Care Management.

The practice manager told us they operated an 'open door' policy where non-clinical staff told us had regular opportunities to hold discussions about their work during the week and this was confirmed by the reception staff we spoke with. All staff received annual appraisals which identified learning needs. Non-clinical staff were appraised by the practice manager and clinical staff were appraised by one of the partner nurse practitioners. Staff records demonstrated that all appraisals were up to date. We saw performance and personal development were discussed at these meetings. There were arrangements in place to support clinical staff through the revalidation process. For example, the salaried GPs were supported to attend study days in regards to any updates in key aspects of their role such as 'managing palliative care patients.'

All staff we spoke with confirmed that the practice was proactive in providing training and funding for development courses. For example, an administrative apprentice had been supported to attend a health care assistant course and the health care assistant had completed a smoking cessation course.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from out of hour's providers the NHS111 service and local hospital including discharge summaries were received electronically. All relevant staff were aware of their responsibility for passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The duty nurse practitioner was responsible for reviewing these documents and results daily and would take whatever action was required. All staff we spoke with understood their roles and felt the system in place worked well. We were advised that there were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. We were told as there were difficulties in recruiting health visitors in the area, the practice often had ad hoc discussions with the health visiting team when they had serious concerns about patients rather than regular scheduled meetings. We also saw that clinical staff would meet with consultants, diabetologist and community matrons in regards to the case management of their most vulnerable patients.

The practice took part in the 'shifting settings of care' program which supported patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. A mental health worker, employed by the secondary care trust, would attend the practice every two weeks to meet with people recently discharged from hospital. The supported offered was holistic which included information and advice about housing, income, social and general health. The GP's also had access to consultant psychiatrists help line at Ealing hospital where they would discuss concerns such as medication swaps and co-morbidities. Patients who experienced poor mental health were kept on a register and invited for annual reviews and offered extended appointments. Reception staff we spoke with were aware of signs to recognise for patients in crisis and to have them urgently assessed by a GP if they presented at the practice.

The practice had adopted an integrated care model and as such worked closely with a care coordinator employed by the CCG who supported 20 patients across four practices.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. An electronic system was also in place for making referrals for tests or to see specialists. The practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) and also arranged hospital appointments manually via the phone, fax or



Are services effective?

(for example, treatment is effective)

emails. A record of each referral including the sent date was maintained on a spreadsheet by the administration staff to monitor any delays. Urgent two week referrals for suspected cancer symptoms were faxed and a follow up phone call made after the fax was sent to ensure receipt of referral.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw the practice manager carried out ad hoc audits to assess the completeness of these records and that action had been taken to address any shortcomings identified, for example where care plans had not been updated following reviews.

As most of the clinicians worked part-time the practice operated a 'buddy system' where care of patients was shared between two clinicians. This was discussed and agreed with patients and then documented in patient's records and in care plans.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in relation to assessing a person's capacity to give consent. Clinical staff had received training on the Mental Capacity Act 2005. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. One clinician told us they had carried out a capacity assessment when a patient had attended the practice a number of times for the same medication after having received it.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice kept a register of these patients to help ensure they received the required health checks. These patients were offered annual review appointments with their carers during which they would be supported in making decisions about their care plans.

All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence in patient records to confirm this. The practice also documented in patients notes if they had refused a chaperone when offered.

Health promotion and prevention

All new patients who registered with the practice were offered a health check with the practice nurse within a week of registering. The clinicians were informed of all health concerns detected and these were followed-up in a timely manner. Clinicians told us they would always use their contact with patients to help maintain or improve their general health and wellbeing. For example, they would take a patients' blood pressure and on occasions have offered opportunistic smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 60% of patients in this age group took up the offer of the health check. The practice manager said they did not actively chase up the ones that did not attend, but would opportunistically discuss the check when patients attended the surgery for routine appointments.

The health care assistant had been trained to give advice on smoking cessation and Information about the service was available in the waiting area.

Cervical screening was offered to woman in line with the national guidelines. The cervical screening uptake rate for women whose notes record that a cervical screening test has been performed in the preceding 5 years was 82% percent for the last QOF submission (April 2014) which was better than other GP practices in the Clinical Commissioning Group (CCG) area. The practice sent text message reminders for patients and would follow up patients who did not attend for cervical screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all child immunisations was approximately 95% which was



Are services effective? (for example, treatment is effective)

above average for the CCG. The practice told us they were continually trying to improve their vaccination take up rates for flu as the take up for people over 65 was 68% and for patients defined in a clinical risk group was 44%.

The practice met regularly with the CCG to discuss the implications and share information about the needs of the practice population. This information was used to help focus health promotion activity such as the need to provide more targeted information about how to reduce avoidable accident and emergency attendances. For example, the production of business cards with details of the practice and OOH arrangements including NHS 111.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in

offering additional help as approximately five percent of patients were on a care plan which was reviewed on an annual basis. The practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 85% had received a check up in the last 12 months.

A wide range of information was displayed in the waiting area of the practice and on the practice website to raise awareness of health issues including information on cancer, meningitis in children, flu and measles. There was also information about local health and community resources.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be respectful and courteous towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that staff were kind and considerate and they received compassionate care from staff at all levels. Patients said the care was excellent and staff were friendly, professional and accommodating.

We received 24 completed Care Quality Commission (CQC) comment cards and all of the feedback was positive. Patients commented on the caring nature of the clinicians and support staff.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from the Friend and Family GP feedback survey. The evidence from both these sources showed patients were very satisfied with their experience at the practice. For example, 80% of patients said they were satisfied with the practice and 78% of people in the national patient survey said they would recommend the practice to someone else. In the national patient survey 90% rated their overall experience as very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 88% of practice respondents saying the GP was good at listening to them and 85% saying the GP gave them enough time as compared to 50% and 52% respectively for the CCG.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Patients were asked to wait behind a line at reception to protect patient's privacy. During our inspection patients were consistently reminded to observe this rule.

Staff told us that if they had never witnessed any instances of discriminatory behaviour or where patients' privacy and dignity had not been respected. They said there was a proportion of their patients whose circumstances made them vulnerable such as homeless people or people experiencing poor mental health, who often came to the surgery but the practice was clear about its zero tolerance for discrimination and made it clear to all patients. Staff training records showed that all staff attended equality and diversity training.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice better than the CCG average. For example, data from the national GP patient survey from 2014 showed 76% of practice respondents said the GP involved them in care decisions and 79% felt the GP was good at explaining treatment and results compared to the national average of 52% and 50% respectively.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and were given enough information to make informed decisions about the choice of treatment they wished to receive. Patient feedback from the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. There was an automated check-in machine in the waiting room and this was available in five languages.

The care plans we reviewed clearly demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this feedback. For example, patients described how staff responded compassionately when they had been diagnosed with serious conditions and provided support when required.

Notices in the patient waiting room and information on the patient website signposted people to a number of support groups and organisations. The practice's computer system

Are services caring?

alerted GPs if a patient was also a carer. Carers were asked to complete carer's forms where appropriate, and there were written information available for carers to ensure they understood the various avenues of support available to them.

There was a robust system of support for bereaved patients provided by the clinicians and other support organisations. Clinicians told us they would make phone calls to families who had suffered bereavement. This would then be followed by a visit at a flexible time and/or location to meet the family's needs. People were given the option to be

referred for bereavement counselling or signposted to a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice maintained a list of patients receiving end of life care and this was available to the out of hours provider. The practice worked closely with the palliative care nursing team and held quarterly meetings with them. Deaths of patients were discussed at the practice daily huddle meetings and monthly practice team meetings.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to the needs of their local population. They used a risk stratification tool designed to identify patients at highest risk of attending A&E or being admitted to hospital, and also to enable the GPs to have peer to peer discussions regarding patients with similar health concerns. The risk tool helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice attended a monthly network meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised. We saw minutes of meetings and saw topics discussed included avoidable A&E attendances, integrated care pathways and developing closed working relations with care homes.

The practice had clinical leads for a variety of long term conditions including diabetes, asthma, chronic obstructive pulmonary disease, learning disabilities and mental health.

Patients over 75 years had a named GP to co-ordinate their care. The practice had a list of older people who were housebound whom they would visit regularly, particularly frail older patients. An Age UK support worker attended the practice three days a week, to support older patients who live on their own. Their role included befriending, attending patients' homes to carry out small repairs like replacing light bulbs and changing plugs, liaising with social services and acting as advocates. The support worker told us they also arranged for equipment to be fitted, such as stair lifts. They also provided transport to improve access for those patients who are house bound or find it difficult to get to the surgery. Patients told us they liked being able to attend the surgery. This improves socialisation and reduces the amount of home visits required by the practice thus increasing the number of appointments being offered to the rest of the population. The practice also worked closely with palliative nurses to ensure older patients with terminal illnesses were supported appropriately at home.

The practice was instrumental in setting up an Ealing wide approach to the three tier model of shared care for diabetes which meant tier one patients were supported by

nurse led diabetes clinics, tier two patients were supported by community based clinics for each health network coupled with telephone and email support and tier three was hospital care. This pilot project was part of a major redesign of diabetes care across Ealing and led to more diabetic nurse specialist being appointed including a Diabetic nurse consultant for the borough and weekly satellite clinics.

The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed.

One nurse practitioner at the practice carried out spirometry tests and liaised regularly with the GP that managed the care of patients diagnosed with chronic obstructive pulmonary disease (COPD). They also provided a weekly clinic for patients registered at other local practices.

The practice kept a register of vulnerable patients and the top 2% of their most vulnerable had alerts on their records so that they were prioritised when they contacted the practice. Staff would also follow up on attendance and results when patients in this group were referred for tests and medical procedures. This ensured they were able to inform GP's when patients had not attended for tests.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, they secured some disabled parking spaces for patients.

Tackling inequity and promoting equality

We were told by staff that a high proportion of the practice population did not speak English as their first language. The practice used a telephone translation service and the automated checking in machine located in the waiting room was in five different languages.

The premises were accessible to patients with disabilities, although it was based on the first floor there was lift access to the first floor and the toilets were accessible to



Are services responsive to people's needs?

(for example, to feedback?)

wheelchair users. The corridors were wide enough to accommodate mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

We saw that the practice had recognised the need for equality and diversity training for its staff which was part of their mandatory training. Staff we spoke with confirmed that they had had discussions in practice meetings about equality and diversity issues and that it was regularly discussed at staff appraisals and team events.

Access to the service

The practice was open from 8am to 6.30pm Mondays, Tuesday, Wednesday and Fridays. The practice had extended opening hours on Thursdays 8am to 8pm and was particularly useful to patients with work commitments. The telephones were manned from 8.00am to 6.30pm daily. Appointment slots were available throughout the opening hours, except between 1pm and 2pm daily, when the practice was closed for lunch although patients could attend specialist services or see the nurse during the lunch hour. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Comprehensive information was available to patients about appointments on the practice website which allowed patients to book appointments and home visits, order repeat prescriptions and access test results. Information was displayed in the practice waiting room and on the website directing patients to the NHS 111 and the out of hour's service when the practice was closed. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hour's service was also provided to patients in the practice information leaflet.

Patients told us they were satisfied with the appointments system. Comments received from patients showed that

patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. All patients we spoke with told us they had always been able to get an emergency appointment and if they had not been able to see a clinician the same day, they said they were able to talk with them on the phone.

Feedback from the national GP survey published in 2014 was positive about the appointment system. 80% of respondents described their experience of making an appointment as good and 96% were satisfied with the surgery's opening hours. Feedback from completed Care Quality Commission (CQC) comment cards was also positive about the appointment stating they could always get an appointment when needed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice's complaints policy and procedure were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. There was also information about how to contact other organisations such as NHS England to make a complaint displayed on the walls. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample of complaints received in the last twelve months and found these were dealt with in a timely way in line with the complaints policy and there were no themes emerging.

The practice kept a complaints log and we were told by staff that complaints were regularly discussed and any learning or changes to practice disseminated to all staff. For example, as a result of a complaint from a patient who felt they were not consulted appropriately about a course of treatment, we saw that all staff were reminded of the practice's philosophy of 'no decision about me – without me'.

Are services well-led?

Outstanding



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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Details of the vision and practice values were part of the practice's annual business plan and on their website and displayed in all the treatment rooms. The practice vision and values was 'to provide people registered with the practice with personal health care of high quality and to seek continuous improvement on the health status of the overall practice population. We aim to achieve this by developing and maintaining a happy multidisciplinary practice which is responsive to people's needs and expectations and which reflects whenever possible the latest advances in Primary Health Care.'

We spoke with eight members of staff and they all knew and understood the vision and values.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there were leads for health and safety, safeguarding and IT. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff had to read the key policies such as safeguarding, health and safety and infection control as part of their induction. All seven policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly management update meetings which were attended by the partners, the practice manager. We looked at minutes from these meetings and found that performance, quality, training and accounts had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above national standards. They had scored 995.5 out of 1000 in 2013 and 896 out of 900 in 2014, which was 6% above the CCG average and 6.1% above England average. There was a

clinical lead for the different areas of the QOF and we saw an action plan had been produced to maintain or improve outcomes. We saw QOF data was regularly reviewed and discussed at the practices monthly meetings.

The practice took part in a peer reviewing system with neighbouring GP practices in Ealing. We looked at notes and saw that they met quarterly and discussed topics such as A&E attendances, referral pathways and inappropriate referrals to secondary care. It was also an opportunity for practices to work together to develop services focused on the needs of the local population for example nursing homes and residential care.

One of the nurse practitioners sat on the board of directors for the federation of local practices, which was a peer review group that focused on quality and productivity of practices in the borough. Another GP partner sat on the CCG board. We saw that information from both these forums were fed back to practice staff at monthly practice meetings.

The practice had completed a number of clinical audit cycles, for example, we saw an audit of patients with chronic asthma who had received an annual assessment. On first audit the percent who had a medication review and annual review was 51%. After intervention, on re-audit the percent had increased to 68%.

The practice had robust arrangements in place for identifying, recording and managing risks. Identified risks were included on a risk matrix maintained by the practice manager which graded risks as low, moderate, high and extreme. Each risk was assessed, graded and mitigating actions recorded to reduce and manage the risk. We saw that the risk matrix was regularly discussed at practice meetings and updated in a timely way.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there were GP leads for infection control, safeguarding and mental health. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that practice meetings were held regularly, every six weeks. Staff told us that there was an

Are services well-led?

Outstanding 

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

open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. They felt they worked well together and that they were a highly functional team which listened and learnt, and were aware of their areas of weakness such as the need to improve asthma medication reviews. Staff said the leadership team were always open to suggestions.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, the recruitment and qualification checking procedure. We were shown the staff handbook which was available to all staff. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

The practice was instrumental in setting up an Ealing wide approach to the three tier model of shared care for diabetes which meant tier one patients were supported by nurse led diabetes clinics, tier two patients were supported by community based clinics for each health network coupled with telephone and email support and tier three was hospital care.

We found the leadership promoted a culture of learning and quality improvement and saw clear evidence of integrated care at the practice. For example working with the Age UK care coordinator and the 'shifting settings of care' program.

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

The practice had an active patient participation group (PPG) which met quarterly. Information about the PPG was available on the practice website and displayed on notice boards in the waiting room. The PPG included representatives from various groups including, older people and carers. However, the practice recognised that the group was not representative of the practices patients for example patients from different ethnic and cultural backgrounds there were no young people. We saw the practice had tried a number of ways to increase the membership including giving out leaflets to patients when they attended appointments. We saw that they had clear written objectives that were distributed to members. Meetings were held quarterly and one clinician and the practice manager attended. We were given minutes of the last meeting dated 27/1/15 and saw that they had discussed electronic prescriptions, practice/patient

communication, patient survey and re-launch of the group. We met with members of the PPG who were very enthusiastic and knowledgeable of the pressure in the NHS and primary care and the chair told us they had consulted with the national association of patient groups for advice when they had been asked to become the chair.

The practice had gathered feedback from patients through the friends and family test, comment cards and complaints received. We looked at the analysis of two recent friends and family surveys and saw that one area looked at was how likely patients were to recommend the practice to other people. The results showed 65% were extremely likely and 35% were likely. We saw that as a result the practice had decided to continue requesting feedback from patients by placing cards on front desk and on noticeboard.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They also told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy and the process to follow if they had any concerns

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. They had the opportunity to feedback on how useful the induction period had been. We looked at five staff files and saw that appraisals had taken place. Appraisals included a personal development plan and staff told us that the practice was very supportive of training.

The GPs and clinical staff held regular clinical meetings where they discussed changes to practice. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. For example we saw a respiratory consultant had attended a clinical meeting and at another meeting a GP had

Are services well-led?

Outstanding



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

prepared a paper on prostate cancer for discussion. We were told these types of sessions encouraged clinical debate, improved clinical management and guided service improvements.

The practice had hosted doctors from abroad who were taking part in a study tour organised by Health Education North West London (HENWL) for trainee doctors in 2014. We saw the practice had been commended for their support of the program, with the participant describing the practice as 'pioneering and innovative.'

The practice scheduled meetings for the whole staff team, clinical, non-clinical and operations management regularly. Staff were encouraged to attend various staff meetings and we saw from the minutes of meetings that they discussed where improvements to the service could be made.

The practice had completed reviews of significant events and other incidents and shared learning with staff via meetings to ensure the practice improved outcomes for patients. For example, following an incident where a two week referral had been placed in the tray for routine referrals, the practice had reviewed and updated the system for requesting referrals.