Dr Sashi Shashikanth

Quality Report

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

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Summary of findings

Overall summary

Dr Sashi Shashikanth, also known as West London Medical Centre, provides GP led primary care services to 4,249 patients living in the surrounding areas of Hillingdon and Uxbridge.

We carried out an announced inspection on 28 August 2014. As part of the inspection process we contacted key stakeholders including Hillingdon Clinical Commissioning Group (CCG) and Healthwatch Hillingdon, and reviewed the information they shared with us. During our inspection we spoke with patients, members of the patient participation group, and practice staff. Most patients told us they were happy with the service and spoke positively about emergency appointments and telephone consultations. Some patients were dissatisfied with the length of time it took to receive a non-urgent appointment. Staff told us they were supported in their role and enjoyed working at the practice.

Many aspects of the service were safe but some areas required improvement. Some GPs had not received the required level of training for child protection. The practice was visibly clean, however arrangements for cleanliness and infection prevention and control were not robustly monitored. We also found that staff who required Disclosure and Barring Service (DBS) checks based on their roles and responsibilities had not received these. However, systems were in place to ensure clinical staff were supported and provided with information required to deliver safe clinical care. All staff were aware of safeguarding and how to escalate concerns, and the practice had policies and procedures to monitor safety and respond to risk.

Many aspects of the service were effective but some areas required improvement. Clinicians were aware of their responsibilities under the Mental Capacity Act (2005) and the circumstances in which mental capacity assessment may be required. The practice received multidisciplinary support from a variety of health care professionals. The practice was proactive in health promotion, and ran a nationally recognised weekly 'healthy walk' activity for patients. The practice was participating in audits to monitor and improve the quality of care but could not yet demonstrate completed audit cycles. Some clinical staff did not always document that verbal consent to treatment had been obtained. There were also no formal systems to monitor staff training.

The practice provided a caring service. Patients were treated with dignity and respect. Staff were aware of consent and confidentiality procedures. The practice identified the needs of different groups of patients and referred them to support services when required.

The practice provided a responsive service. Patients' needs were understood and influenced the care delivered. The practice was accessible to patients with mobility needs, and there were systems in place to assist patients who have a hearing impairment and patients who do not speak English. The practice offered extended hours on certain days when patients could see a GP or nurse. The practice reviewed and responded to complaints, however they lacked a formal system for documenting their actions and learning achieved.

Many aspects of the service were well-managed. There was strong leadership from the GP principal, who had the dual role of GP principal and practice manager. Governance arrangements were in place with identified leads for specific areas of the service. The practice sought the views of patients via surveys and the patient participation group, and made changes in response. The practice could do more to ensure practice meetings were formally scheduled and documented. The practice also needed to update its policies and procedures, and ensure staff reviewed these.

The provider was in breach of regulations related to:

- Cleanliness and infection control
- Records
- Requirements relating to workers
- Supporting workers

The majority of patients registered at the practice were above the age of 65, and the annual flu campaign was aimed at these patients. Multidisciplinary input was received for patients with complex health needs, and patients were signposted to emotional support services.

The practice were knowledgeable about the health needs of patients with long term conditions, and encouraged

Summary of findings

patients with conditions such as asthma, chronic obstructive pulmonary disease, diabetes, and coronary heart disease to attend the practice for reviewing and monitoring.

The practice offered a baby clinic for the six-week baby check, immunisations and mother's post natal care. GPs met with the health visitor every two months. Children's immunisation history was checked during registration with the practice and immunisations were offered.

The practice offered extended opening hours, telephone consultations and email correspondence to meet the needs of working age people and those recently retired. New patient health checks were performed during registration with the practice, and patients aged 40-74 were offered the NHS health check.

All patients with learning disabilities had received their annual health check. Carers needs were identified and support was provided. Staff had received vulnerable adults training and were aware of how to escalate concerns.

The practice supported patients experiencing poor mental health and were able to refer to different community services to meet the needs of the patient. GPs had good knowledge of mental capacity and were aware of when they may need to assess this.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Many aspects of the service were safe but some areas required improvement. Systems were in place for reporting and learning from significant events, however there was no follow-up to ensure the changes made had led to sustained improvements. There were policies in place for safeguarding children, however some GPs had not received the required level of child protection training. Named staff members had responsibilities for medicines management, however there were no records to confirm when medicines were checked. Although the practice was visibly clean, arrangements for cleanliness and infection prevention and control were not robustly monitored. The practice did not have cleaning schedules in place, no audits or risk assessments had been carried out to monitor infection prevention and control, and some staff had not received any training. We also found that staff who required Disclosure and Barring Service (DBS) checks based on their roles and responsibilities had not received these.

The practice did have systems in place to ensure clinical staff were supported and provided with information required to deliver safe clinical care. The GP principal had a debrief with the sessional GPs after each clinical session. Protocols were in place for managing patients taking high-risk medicines and arrangements were in place for monitoring repeat prescriptions. All staff were aware of safeguarding and how to escalate concerns, and the practice had policies and procedures to monitor safety and respond to risk.

Are services effective?

Many aspects of the service were effective but some areas required improvement. The practice followed guidance around treatment and prescribing. GPs had knowledge of the Mental Capacity Act (2005) and were aware of when they may need to assess mental capacity. The practice worked with a variety of health care professionals and support services for multidisciplinary input and coordinated care. There was emphasis on health promotion and the practice had an in-house smoking advisor for smoking cessation. The practice also advertised and ran a weekly 'healthy walk' activity for registered patients. The practice premises had been renovated and patients commented positively about the practice environment.

Whilst the practice undertook audits and detailed the learning achieved, they had yet to demonstrate completed audit cycles.

Summary of findings

Consent was obtained from patients prior to treatment, however some clinical staff did not always document this. There was evidence that staff engaged in training however there were no formal systems to monitor this.

Are services caring?

The practice provided a caring service. Patients were treated with dignity and respect. Staff were supported to be compassionate when speaking with patients, and were aware of procedures maintaining confidentiality. The practice had identified carers and were aware of their needs. The practice made referrals to a variety of emotional support services, and specific protocols were followed when the practice were notified of a bereavement.

Most patients felt involved and supported when making decisions about their care and treatment. The National Patient Survey (2014) found that respondents rated the overall experience of the GP surgery as good, which was above the regional average.

Are services responsive to people's needs?

The practice was responsive to the needs of patients. Patients' needs were understood and influenced the care delivered. The practice worked as part of a multidisciplinary team to care for patients with complex needs, and a physiotherapy service was available on-site. The premises were accessible to patients with mobility needs, and there were systems in place to assist patients who had a hearing impairment and patients who did not speak English. Patients spoke positively about telephone consultations with the GPs and communicating with staff via email. Although the practice offered extended hours, some patients said they could not access appointments when they needed them. The practice conducted patient surveys and received input from the patient participation group to improve the service. The practice reviewed and responded to complaints, however they lacked a formal system documenting the actions they had taken and any learning achieved as a result of feedback.

Are services well-led?

Many aspects of the service were well-led and well-managed. There was strong leadership from the GP principal, who held the dual role of GP principal and practice manager. Governance arrangements were in place with identified leads for specific areas of the service, and this included the delegation of practice manager tasks to senior administration staff. The practice had a business continuity plan in

Summary of findings

the event of disruption to the service. The practice sought the views of patients via email, practice surveys, and the patient participation group. Staff felt supported in their roles and described a positive culture of openness within the practice.

The practice could ensure practice meetings were formally scheduled and minuted. Some practice policies and procedures required updating, and some staff had not reviewed the policies in place.

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
The majority of patients registered at the practice were above the age of 65, and the annual flu campaign was aimed at these patients. Multidisciplinary input was received for patients with complex health needs, and patients were signposted to emotional support services.

People with long-term conditions
The practice was knowledgeable about the health needs of patients with long term conditions, and encouraged patients with conditions such as asthma, chronic obstructive pulmonary disease, diabetes, and coronary heart disease to attend the practice for review and monitoring.

Mothers, babies, children and young people
The practice offered a baby clinic for the six-week baby check, immunisations and mothers' postnatal care. GPs met with the health visitor every two months. Children's immunisation history was checked during registration with the practice and immunisations were offered.

The working-age population and those recently retired
The practice offered extended opening hours, telephone consultations and email correspondence to meet the needs of working age people and those recently retired. New patient health checks were performed during registration with the practice, and patients aged 40-74 were offered the NHS health check.

People in vulnerable circumstances who may have poor access to primary care
All patients with learning disabilities had received their annual health check. Carers' needs were identified and support was provided. Staff had received vulnerable adults training and were aware of how to escalate concerns.

People experiencing poor mental health
The practice supported patients experiencing poor mental health and were able to refer to different community services to meet the needs of the patient. Clinicians were aware of their responsibilities under the Mental Capacity Act (2005) and the circumstances in which mental capacity assessment may be required.

Summary of findings

What people who use the service say

Most patients we spoke with told us that they were happy with the service provided by the practice. Patients told us that they had received an emergency appointment when required, and that staff were polite. The main issue raised related to the waiting time to receive a non-urgent appointment, and some patients said that the opening hours were not suitable for them. Comment cards received were positive, with most patients stating they were happy with the service.

The practice had recently conducted a patient survey. It had received 150 responses and the results had been discussed with the patient participation group (PPG). The practice had made some changes in response to the results of the survey. The National Patient Survey (2014) found that 86% of respondents rated the overall experience of the GP surgery as good, which was above the regional average.

Areas for improvement

Action the service MUST take to improve

- The practice must ensure all GPs receive Level three child protection training.
- The practice must assess the different responsibilities and activities of staff, and undertake criminal record checks at the appropriate level for staff that require them.
- The practice must have effective systems to ensure patients are protected from the risk of a health care associated infection.

Action the service SHOULD take to improve

- The practice should formalise procedures to follow-up significant events.
- The practice should have records to confirm medicines have been checked for stock control and expiry.
- The practice should demonstrate completed audit cycles to monitor and improve the quality of care.
- The practice should have procedures to formally monitor, record and evaluate staff learning.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

- The GP locums met with the GP principal after each clinical session for a debrief ensuring continuity of care.
- The practice commissioned an on-site physiotherapy service which enabled patients to be seen in a familiar environment.
- The practice had received national recognition for running a weekly 'healthy walk' activity for its patients.
- The practice worked with nurses from the British Heart Foundation to support patients with cardiac conditions.

Dr Sashi Shashikanth

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. The CQC Lead inspector was accompanied by a CQC inspector and a variety of specialist advisors: two GPs, a healthcare manager, and an expert by experience. They were all granted the same authority to enter West London Medical Centre as the CQC inspectors.

Background to Dr Sashi Shashikanth

Dr Sashi Shashikanth, also known as West London Medical Centre, provides GP led primary care services to around 4249 patients living in the surrounding areas of Hillingdon and Uxbridge. The proportion of people above the age of 40 living in the London borough of Hillingdon is below the England average, however the practice informs us that it has a higher proportion of patients over the age of 65. The most widely spoken languages in the area after English are Panjabi, Polish and Tamil.

Dr Sashi Shashikanth holds the dual role of GP principal and practice manager. In addition to the male GP principal, there are two male and two female GP locums. Other clinical staff include two practice nurses, and a health care assistant. There are eight administration staff and two domestic staff. The GP principal works nine sessions per week and the four GP locums cover eight sessions per week. The senior practice nurse works 24 hours per week, and the assistant practice nurse and the health care assistant each work eight hours per week.

The practice is open every weekday 08.00 to 18.00 except on Wednesday afternoons when it closes at 1pm. Extended hours are offered with the GPs from 07.30 on Wednesday. Extended hours are offered with the nurses on Thursday till 19.00 and from 07.30 on Friday. The practice opted out of providing out-of-hours services to its own patients. On Wednesday afternoons and outside of normal practice hours patients are directed to an out-of-hours service or the NHS 111 service.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before our inspection we reviewed a range of information we hold about the practice. As part of the inspection process we contacted a number of key stakeholders which included Hillingdon Clinical Commissioning Group (CCG) and Healthwatch Hillingdon, and reviewed the information they shared with us.

We carried out an announced inspection on 28 August 2014. During our inspection we spoke with a range of staff including: the GP principal; two GP locums; the senior practice nurse; the health care assistant; and three administration staff. We observed how patients were being cared for and sought the views of patients. We spoke with three patients on the telephone and ten patients in person on the day of our inspection. We also spoke with two members of the patient participation group prior to our inspection. We reviewed 23 comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures.

Are services safe?

Our findings

Safe track record

Clinical staff were provided with information required to deliver safe care. The GP principal sent daily emails to clinical staff informing them of safety alerts and any updates on best practice guidance. Clinical meetings were not formally scheduled, however the GP principal informed us that he had regular debriefs with the other GPs after each clinical session. The other GPs confirmed these debrief sessions and stated they were important for continuity of information and care. The practice had arrangements for reporting and recording incidents and it was the responsibility of the GP principal to review and investigate all incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed four significant event analyses, which showed the practice had examined the event and taken remedial action. One incident involved an urgent call not being relayed to the GP. The practice had since identified an option on the computer system to alert GPs in such events. The practice had yet to follow-up to ensure the changes made were maintained to improve the safety of the service.

Reliable safety systems and processes including safeguarding

The practice's child protection policy contained named contact details for the local children's safeguarding team. The GP principal was the safeguarding lead for the practice, however he had only received Level 2 child protection training. All GPs must have received Level 3 training. We checked the training records of the locum GPs and found one GP had received Level 3 training, one GP had received Level 2 training, and the other two GPs received child protection training but the Level was not verified on their documentation. Records showed that one practice nurse had completed child protection training to Level 3, and the other practice nurse and the health care assistant had completed Level 2 training as required. We checked the training records for three members of the administration team and found they had received child protection training to Level 2. Staff had an awareness of safeguarding, who the lead was, and how to escalate concerns.

The practice had a vulnerable adults policy which contained contact details and a referral form for the local adult safeguarding team. We saw evidence that all staff had undergone training in the safeguarding of vulnerable adults.

There was a chaperone service for patients wishing to have someone of the same gender present during intimate examinations. This information was displayed in the waiting room and on the practice website. Clinical staff usually acted as chaperones. Administration staff who had received in-house and online training also acted as chaperones and were able to describe their role effectively.

Staff were aware of the concept of 'whistleblowing' and how to access the practice's whistleblowing policy, however most staff told us they had not reviewed the policy.

Monitoring safety and responding to risk

The practice had systems in place to monitor and respond to risk. There was an anaphylaxis treatment policy and Epipens, which contained adrenaline, were available as an emergency drug and kept in all clinical rooms in the event of a patient experiencing anaphylactic shock. The GP principal told us the only other emergency drug kept at the practice was glyceryl trinitrate (GTN) spray. We spoke to the GP principal about the benefits of a more complete resuscitation trolley.

The practice stored adrenaline in each consultation room for use in an emergency. These medicines were checked and in date. An oxygen cylinder, which was kept in the nurse's room, was full and in good working order. All staff had received basic life support training and were aware of where the oxygen was stored. Staff were able to describe what action they would take when responding to a medical emergency and provided an example of when a patient was taken ill in the waiting room. Emergency protocols were followed and the patient was provided oxygen and monitored until the paramedics arrived. The practice did not have an automated external defibrillator (AED). Staff told us this was because the local hospital was a few minutes away, and in a recent medical emergency the ambulance arrived in less than four minutes.

Are services safe?

The practice had systems in place to monitor and respond to risk. There were policies and procedures for health and safety, fire safety, sharps accidents, and significant events. Protocols for business continuity in the event of disruption to the service were also documented.

Medicines management

General repeat prescribing was reviewed every two months by the GP principal. For safety reasons some medicines, such as antidepressants, were not available as a repeat prescription and a patient would need to consult a doctor before a prescription was issued. Repeat prescriptions could be requested in person, via e-mail, post, fax or by pharmacist request. It was the practice's policy not to accept orders over the phone for safety reasons. Designated administrative staff dealt with repeat prescriptions and were able to describe their duties. The practice did not have written prescription protocols for current or new members of staff to refer to. The GP principal told us that new staff would not deal with repeat prescriptions immediately and were always supervised by a senior member of the administration team.

There were protocols in place for managing patients taking high-risk medicines such as methotrexate. Prescribing for methotrexate was by a shared protocol with hospital consultants. The practice could access the hospital records system for on-going monitoring, and repeat prescribing was carried out by the GP principal for high-risk medicines.

The practice had some arrangements in place to ensure medicines kept at the practice were checked and stored securely. Named staff members were responsible for checking, rotating and ordering medicines. However, there were no records to confirm what stock was present and when medicines expired. The nurse was responsible for checking vaccines were stored at the optimum temperature, and administrative staff fulfilled this role in the nurse's absence. We checked a sample of vaccines and found all were in date. Vaccines were stored in a locked fridge and the room was locked if it was unattended for a prolonged period. The fridge temperature was recorded twice daily and was within range.

Cleanliness and infection control

The practice did not have robust arrangements in place for infection prevention and control. The practice's policy on infection prevention and control identified one of the practice nurses as the clinical lead, and the senior administrator as the non-clinical lead.

The practice was visibly clean. Consultation rooms had equipment in place to reduce the risk and spread of infection. Hand washing instructions were clearly displayed in clinical areas and hand sanitizer was available to patients in the waiting room. Clinical waste was stored securely in a separate room within the practice, and disposal of clinical waste was undertaken by a local hospital.

The domestic supervisor was responsible for cleaning clinical and non-clinical areas every evening following surgery hours. The practice's policy referred to a 'cleaning specification' which should be followed by domestic staff on a daily, weekly, monthly and six-monthly basis. However, staff confirmed there were no cleaning schedules or records to confirm what cleaning tasks had been undertaken for clinical and non-clinical areas. The practice's policy stated that random unannounced inspections would be completed by staff and the findings reported, however we did not see evidence that these checks or any other audits were completed for infection prevention and control. The practice had also not assessed the risk of Legionella in the water system. The practice nurse who was clinical lead and the health care assistant had completed recent training in infection prevention and control, however we did not see evidence that other staff received training.

Staffing and recruitment

The practice had a 'newly employed staff' policy which applied to the recruitment of clinical and administrative staff. Senior administration staff were able to describe the recruitment and interview process. Curriculum vitaes and two references were obtained before employment. The practice's policy determined which staff were eligible for Disclosure and Barring Service (DBS) checks based on their roles and responsibilities, however the practice were not always following this policy. There was evidence that all GPs, and one of the practice nurses had DBS checks done. We were told the other practice nurse and HCA were checked with their previous employer, however the practice did not have documented evidence of this. We also found that the two non-clinical staff who carried out chaperone duties had not undergone a DBS check. The practice informed us they would make arrangements for these staff to undergo DBS checks.

Are services safe?

Dealing with Emergencies

The practice had a business continuity plan which covered arrangements for a number of potentially disruptive events. There was a separate protocol for backing up computer data on a daily basis. Reception staff also printed out patient lists for the following day in case there were problems with the computer systems.

Equipment

Records confirmed that clinical equipment had been calibrated and the practice's boiler had been serviced this year. Electrical appliance testing had not been carried out, and the GP principal told us this would be arranged.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice followed National Institute for Health and Care Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) guidance around treatment and prescribing. The practice received regular updates regarding referral pathways from the Clinical Commissioning Group (CCG), and staff were able to access these pathways electronically. All referrals were triaged by the GP principal to ensure they were appropriate. An example of a referral pathway was the clinical assessment and treatment service, which triaged musculoskeletal referrals to the local hospital. If a patient requested to be seen at another hospital, the practice used the "Choose and book" system to enable them to choose a suitable provider and convenient appointment. The practice also had direct access to a private healthcare provider for MRI referrals which was commissioned by the local CCG.

A recent medicines management review had been conducted at the practice. The practice used the data from the review to make recommended changes in prescribing. An example that had been implemented was changing the brand of diabetic strips prescribed.

The practice's consent policy included obtaining the consent of children and referred to the Gillick competency test. The GPs we spoke with had knowledge of the Mental Capacity Act (2005) and were aware they may need to assess mental capacity when treating patients with learning disabilities and dementia. One member of the nursing team told us she always sought consent before administering a vaccination but did not always document that verbal consent had been obtained.

Management, monitoring and improving outcomes for people

Data from the Quality and Outcomes Framework (QOF), a system detailing GP practice achievement results, showed that the practice was performing well in medicines management. The practice was involved in benchmarking with the Clinical Commissioning Group (CCG). Information received from the CCG was assessed by the GP principal and sent to relevant practice staff via email. Monthly medicines audits were sent to the CCG, and we viewed submitted data from previous months. The practice had made changes to prescribing as a result of the audits.

The GPs undertook clinical audits. An example included a hypertension audit which showed 40% of patients did not achieve the follow-up planned. As a result the practice reviewed its follow-up procedures to include telephone reminders, letters and an alert in the GP system. The audits we viewed did not have completed second cycles to monitor improvement, however the GPs were able to discuss their plans to complete second cycles after 12 months.

Effective Staffing, equipment and facilities

The GP principal was a GP appraiser and the GP lead for continuing professional development (CPD) in Hillingdon. He ran the Independent Hillingdon GP Group and organised monthly educational masterclasses for local GPs. The GP locums told us they attended these masterclasses and we saw evidence that staff engaged in CPD. All GPs had completed their annual GP appraisals. One GP had undergone revalidation in April 2014, and four GPs were due for revalidation in 2014, 2015, and 2018. The practice nurses were appraised annually by a designated GP, but had yet to undergo appraisal for this year.

Administrative staff had received training in basic life support, health and safety, safeguarding adults, child protection, confidentiality, customer service, equality and diversity, and complaints. However there was no formal system to monitor staff training or identify when training required updating.

The practice had undergone some significant changes over the last three years, such as moving into and renovating the new premises to improve safety and access for patients, and creating a better working environment for staff. Patients spoke positively of the practice environment.

Working with other services

The practice worked with other services to coordinate care. Multidisciplinary meetings were held every two months with the health visitor, district nurses and community matron to discuss the care of patients with complex needs and those requiring palliative care. We reviewed minutes from these meetings. The practice received fax updates from the district nurses, and prescription requests were actioned the same day. The GP principal provided an example of where joint working with the community matron helped to reduce a patient's hospital admissions. Another example involved the pharmacist contacting the

Are services effective?

(for example, treatment is effective)

GP about a 'confused' patient who lived alone. The GP saw the patient at the practice and made a referral to social services, who carried out a "rapid response" assessment of the patient's needs in their home.

The practice liaised with a mental health consultant to discuss patient referrals. Staff told us that the practice managed most mental health conditions in-house, however patients could be referred to three community mental health teams for assessment and brief treatment, long-term and enduring mental health problems, and acute psychosis.

Outside of practice hours patients were directed to an out-of-hours service. The practice received notifications by fax each morning before the start of surgery, and these were immediately scanned on to the practice database for the GP principal to review. The practice also communicated with the out-of-hours service to notify them of patients on the palliative care register. The out-of-hours contact number was available to patients in the practice leaflet and on their website, and all patients we spoke to said they were aware of how to contact the out-of-hours GP service.

The GPs screened and actioned all test results the same day. The GP principal ensured there were no outstanding results to be screened on Friday evenings, and also checked on Sundays for any results that may have arrived over the weekend. Patients could make an appointment or telephone the practice at a designated time to discuss their results.

Health, promotion and prevention

All new patients were offered a consultation with the health care assistant and were not registered with the practice until they attended this check-up. We saw reminder letters which were sent to patients who failed to attend their appointment. Health issues identified during the check-up were escalated to a GP if required.

Health promotion information was available in the waiting room, the nurse's room and on the practice website, and included leaflets on various conditions, screening services, and immunisations. Enhanced services are primary medical services offered by practices in addition to the essential services required of them. The practice was providing enhanced services on smoking cessation, and alcohol screening and related risk reduction. The practice had an in-house smoking advisor who offered smoking cessation advice, and was able to measure and inform patients about carbon monoxide levels in their blood. Alcohol and drug screening was provided by the health care assistant.

The practice placed emphasis on obesity management, especially childhood obesity, and promoted physical activity. Patients' weight and exercises levels were monitored during consultations, and the practice provided patients with diet information sheets and referrals to the hospital dietician. The GP principal told us he discussed the value of exercise with patients and that medical forms required for weight loss programmes or gymnasiums were completed without charge. The practice had received national recognition for running a weekly 'healthy walk' activity for its patients. The walks were advertised in local magazines and involved patients meeting at the surgery and walking together for 45 minutes.

There was a palliative care register and the practice had good knowledge of the two patients in receipt of care.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Our findings were based on what we saw in the National Patient Survey (2014), a survey of 150 patients undertaken by the practice, the 23 CQC comment cards completed by patients, and the views of the 13 patients we spoke to before or on the day of inspection.

The practice had systems in place to respect patients' privacy and dignity. Clinical rooms had privacy screens for use during examinations and a chaperone service was available during intimate examinations. Patients were offered a choice of seeing a male or female GP. Staff spoke about compassion and understanding when communicating with patients, and were reassured by the support they received from senior staff. Patients told us their privacy and dignity was always respected.

We spoke to reception staff about confidentiality in the practice. Staff were aware of the practice's confidentiality policy, and told us they would close the glass window at the reception desk when they answered the phone or were not liaising with patients so that confidentiality could be maintained. We observed this occurring during our inspection. Staff told us if a patient requested to discuss sensitive issues they could use a private room within the practice, and there was a poster informing patients of this. Most patients we spoke to said they had been treated with confidentiality at the practice.

The practice made referrals to emotional support services such as the Improving Access to Psychological Therapies (IAPT) team at a local hospital site, Social Services, Age Concern, Relate, Mind and the Alzheimer's Society. Specific protocols were followed when the practice was notified of a bereavement. The GP principal sent a letter of condolence and support to the family. Patients were initially signposted to attend the practice to speak with the GPs, and were offered bereavement counselling at a local hospice. An information booklet on bereavement was provided to patients. Two patients we spoke with confirmed they had been offered referral to an emotional support service.

The practice had identified carers and were aware of their needs. There was a carers protocol in place, and referrals were made to social services for assessment when needed.

Involvement in decisions and consent

The National Patient Survey (2014) found that 86% of respondents rated the overall experience of the GP surgery as good, which was above the regional clinical commissioning group (CCG) average of 80%. Most patients we spoke to felt involved and supported when making decisions about their care and treatment, and said they received appropriate communication from staff. One patient said they had been through a recent health scare and were kept informed throughout. Another patient said they were impressed that the practice contacted them to discuss smoking cessation.

The recent practice survey showed 92% of respondents scored medical staff and clinical care at the practice as 7 or above out of 10. The National Patient Survey asked patients about the last GP they saw or spoke to, and 71% of respondents said the GP was good at involving them in decisions about their care which was above the CCG average of 69%, and 76% said the last GP they saw or spoke to was good at explaining tests and treatments which was marginally below the CCG average of 77%. Results for the same interactions with nursing staff showed 56% of respondents stated the nurse was good at involving them in decisions about their care which was below the CCG average of 61%, and 69% stated the nurse was good at explaining tests and treatment which was marginally below the CCG average of 70%. Patients we spoke with were complimentary about the newly employed nursing staff.

Reception staff had a good understanding of third party consent requirements when giving information over the phone, and this was in line with the practice's confidentiality policy. The GPs we spoke with had knowledge of the Mental Capacity Act (2005) and were aware they may need to assess mental capacity when treating patients with learning disabilities and dementia.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

There was coordinated care to respond to the needs of different groups of patients. Multidisciplinary meetings were held every two months with the health visitor, district nurses and community matron to discuss the care of patients with complex needs and those requiring palliative care. The rapid response team were utilised to ensure patients were safe at home. Staff gave an example of when they liaised with a drug dependency consultant to ensure a patient received expert care for drug dependency.

In addition to the GP principal, there were four regular GP locums who worked at the practice. Patients were given the choice of seeing three male or two female GPs. The practice employed two nurses, one of whom offered specialist screening for diabetes, asthma and coronary heart disease. All doctors were registered with the General Medical Council and the practice nurses were registered with the Nursing and Midwifery Council.

The practice was accessible to patients with mobility difficulties. All consultation rooms were located on the ground floor. The practice had disabled and standard toilet facilities, and a baby changing area. A portable hearing loop was available to assist patients who had a hearing impairment and a sign language interpreter could be requested. Some clinical and administrative staff could speak languages other than English, which aided communication with some patients. The practice also had access to a telephone interpreting service. Home visits were arranged for patients who could not access the service and these were triaged by the GPs.

The recent practice survey received 150 responses over a two week period, and was analysed by staff and discussed with the Patient Participation Group (PPG). The results showed that most patients were happy with the service and that it met their needs, and we found this was the case when speaking with patients about their care and treatment. The practice had attempted to address issues identified and documented their actions to date. An improvement made to the waiting room following the survey included installing hand sanitizers on the walls.

Access to the service

The practice was open every weekday 8.00 to 18.00 on all days except Wednesday. On Wednesday afternoons and outside of normal practice hours patients were directed to an out-of-hours service or the NHS 111 service. This information was available to patients in the practice leaflet and on the website, and all patients we spoke with said they were aware of how to contact the out-of-hours service.

The practice had extended opening hours on Wednesday mornings, to accommodate people who could not see a GP during normal working hours. The nurses also had extended hours on Thursday evenings and Friday mornings. The National Patient Survey (2014) found that 72% of respondents were satisfied with the surgery's opening hours, which was the same as the regional clinical commissioning group (CCG) average. We did however receive three CQC comment cards which stated that the opening hours were not suitable for some patients due to work commitments.

There was mixed feedback regarding accessing the service. The National Patient Survey (2014) found that 95% of respondents said the last appointment they got was convenient, which was above the regional CCG average of 88%. We spoke with 13 patients either on the phone or in person. Five patients told us they could not make an appointment when they needed one, and four patients told us they had to wait two to three weeks to receive a non-urgent appointment.

The practice told us some patients wanted to see a specific GP and this resulted in a longer waiting time to receive an appointment. The practice had tried to improve emergency access to the service by providing more telephone consultations. Seven patients told us they had been offered same day emergency appointments and four patients commented that the telephone consultations were very good.

We received 23 CQC comment cards. The majority were very positive about the service. Patients said they found it useful to communicate with the practice via email.

Meeting people's needs

The practice planned and delivered services to meet the needs of different patients. Patients with chronic conditions were encouraged to see the practice nurse for review, monitoring and supervision of treatment. A diabetic clinic was run every Friday afternoon, and patients were able to see the GP and specialist nurse for review. The practice

Are services responsive to people's needs?

(for example, to feedback?)

commissioned an on-site physiotherapy service at the request of the GP principal. This service enabled patients to be seen in a familiar environment and not have to travel elsewhere to receive treatment.

Patients' needs were understood and influenced the care delivered. An example was when a patient did not want to use the out-of-hours services if their blood test result indicated urgent medical intervention. The GP principal advised the patient when to have the blood test done to ensure that the practice could discuss the results.

The GP principal was aware of the best referral pathways and all referrals were screened by the GP principal to ensure they were appropriate. Urgent referrals were confirmed on the electronic system to ensure all patients received timely referrals.

Concerns and complaints

The practice had a system in place for handling concerns and complaints. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the senior administrator was the designated responsible person who handled all complaints in the practice. We reviewed a complaints log which listed recent complaints and the date they were resolved. We saw evidence that complaints were responded to by the senior administrator. Senior staff told us that the practice had previously received some negative feedback regarding the interaction between reception staff and patients. Senior staff informed us that reception staff were provided with customer care training and were observed by senior staff during the working day. Reception staff confirmed they had received training and we saw documented evidence of this. The practice lacked a formal system documenting the action taken by the practice and any learning achieved as a result of patient feedback.

The complaints procedure was available to patients in the practice leaflet and on their website. Some patients we spoke with had made a complaint to the practice and most told us they had received a satisfactory response. Patients who were unaware of the complaints procedure said they felt comfortable raising their concerns with the GP principal.

Are services well-led?

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

Our findings

Leadership and culture

Staff told us there was strong leadership from the GP principal and all staff received supervision and support. Locum GPs met with the GP principal after each clinical session and told us there was good teamwork and support within the practice. The health care assistant was supervised by the senior practice nurse. The nurses were supervised by the GPs. The senior administrator managed the general running of the practice and supervised the administrative team.

The GP principal described his vision for improving services provided for patients, with particular emphasis placed on health promotion. The practice had recruited two nurses this year to help achieve this vision. Staff described the encouragement they received from the GP principal in helping them promote the practice's vision in providing a quality service to patients.

Governance arrangements

Staff roles and responsibilities were clear as the practice had identified leads for different areas such as infection control, health and safety, safeguarding, complaints, and significant events. The GP principal held the dual role of GP principal and practice manager. Five members of the administration team had been delegated practice manager tasks, and these responsibilities had been documented. The tasks were divided into daily, weekly, monthly, quarterly and annual tasks. Staff demonstrated a good understanding of their area of responsibility and tried to ensure high standards of service were maintained when colleagues were on leave. Staff told us that the GP principal oversaw their work and that the system was working well.

Systems to monitor and improve quality and improvement

The three GPs we spoke with described their involvement in clinical audits. The practice was also monitoring and improving the quality of service through its work with the Patient Participation Group (PPG) and analysis of significant events.

We reviewed the practice policies and procedures and found some required updating. They were kept in the office and were accessible to staff, however some staff told us they had not reviewed the policies for safeguarding or whistleblowing.

Patient experience and involvement

The practice had recently formed a patient participation group (PPG) to seek the views of patients. A poster in reception notified patients of the PPG and requested feedback via email or the practice surveys. Patients could complete the practice's questionnaire or leave comments anonymously in a suggestion box in the waiting room. The recent practice survey received 150 responses from patients.

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

Meetings with the patient participation group (PPG) were scheduled every two months depending on feedback received from patients. The group was led by three members of the administrative team, and included four patients. Prior to our inspection we spoke with two members of the PPG, who told us the practice listened to patients' concerns and acted on feedback received through the questionnaires. The practice had made the results of the survey available to patients on their website.

The GP principal and senior administrator informed us that they met regularly with clinical and administrative staff to seek their views, however these discussions were informal and not documented. Staff confirmed they could approach the GP principal and senior administrator on a daily basis, and found them to be open and willing to listen to their concerns and feedback.

Practice meetings were not formally scheduled and were arranged when senior staff needed to relay information to the team. Staff told us the results from the recent patient survey had been discussed in a recent team meeting, however there were no meeting minutes to evidence what was discussed.

Management lead through learning & improvement

There was an appraisal policy stating GPs were appraised externally and, all GPs had undergone annual GP appraisals. One GP had undergone revalidation in April 2014, and four GPs were awaiting revalidation in 2014, 2015, and 2018. The practice nurses were appraised annually by a designated GP, but had yet to undergo appraisal for this year. There was no reference in the policy to administrative staff, however we were told annual appraisals took place and we saw evidence of an appraisal which was completed this year for a member of the administration team.

Are services well-led?

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

Identification and management of risk

The practice had identified risk in areas such as staffing and had addressed these. For example, it was in the process of recruiting a scanning and prescription clerk to reduce the workload of current reception staff. A protocol was in place for business continuity in the event of disruption to the service. This included actions to take in emergency situations such as the incapacity of the GP principal. The protocol took into account the GP principal's pivotal role as both sole partner and practice manager, and described clinical and administrative actions required.

Older people

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

Our findings

The majority of the practice population were over the age of 65. Older patients received continuity of care as the GP principal was the named GP for patients over the age of 75 and worked at the practice full-time. The senior administrator told us she acted as the liaison with elderly patients, and patients often called her to clarify information.

The practice provided an enhanced service for influenza and pneumonia. There was an annual campaign to promote the influenza vaccination for specific patient groups, including those aged 65 and over.

The practice worked closely with other services. Multidisciplinary team meetings were held every two months with the district nurses and community matron to ensure palliative care patients and patients with complex health needs received support. Fax updates were received from the district nurses, and the practice would action prescription requests the same day. The practice made referrals to social services, and urgent referrals were seen by the rapid response team who would ensure patients were safe at home. The practice also made referrals and signposted patients to emotional support services such as Age UK, and the Alzheimer's Society.

Specific protocols were followed when the practice were notified of a bereavement. The GP principal sent a letter of condolence and support to the family. Patients were informed they could attend the practice to speak with the GPs, and were offered bereavement counselling at a local hospice. An information booklet on bereavement was provided to patients. Two patients we spoke with confirmed they had been offered referral to an emotional support service.

People with long term conditions

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

Our findings

The practice was knowledgeable about the health needs of patients with long term conditions. Information on chronic conditions and support services were available to patients in the waiting room, nurse's room and on the practice website.

The practice had recruited a practice nurse who specialised in treating patients with asthma, chronic obstructive pulmonary disease, diabetes, and coronary heart disease. Patients with chronic conditions were encouraged to see the practice nurse for review, monitoring and supervision of treatment.

The practice participated in the local enhanced service for diabetes at "tier 2" level. A diabetic clinic was run every Friday afternoon, and patients were able to see the GP and specialist nurse for review. Patients spoke highly of practice staff, who ensured they had timely reviews at the diabetic clinic.

There was a palliative care register and the practice had good knowledge of the two patients in receipt of care. The practice could do more with advance care planning to improve end of life care so that patients' wishes, needs and preferences were taken into account.

There was an annual influenza vaccination campaign aimed at specific patient groups, including those with long term conditions such as diabetes and asthma.

The practice worked closely with other health professionals. Physiotherapy services and joint injections were offered on site, to assist patients with musculoskeletal problems. Multidisciplinary team meetings were held every two months with the district nurses and community matron to discuss patients with complex health needs. The community matron saw a list of patients with chronic conditions, and was able to visit patients at home, review their medication and provide telephone support. An example of effective joint working was when the community matron helped reduce the anxiety of a patient with chronic obstructive pulmonary disease and asthma, and prevented their hospital admissions. The practice also worked with nurses from the British Heart Foundation to support patients with cardiac conditions.

Mothers, babies, children and young people

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

Our findings

The practice had services to meet the needs of mothers, babies, children and young people. Pregnancy test results were not given over the phone, and patients were required to see a practice nurse to discuss these results. There was a protocol for ante natal and post natal care. Patients were usually referred to Hillingdon Hospital via the "Choose and Book" system. Antenatal services were midwife led and patients were referred to the GP if there were medical concerns. Post natal care involved six-week baby checks and immunisations. Mothers were requested to have an appointment at the same time as their baby, and double appointments were booked for these post natal checks. Multidisciplinary meetings, which the health visitor attended, were held every two months. All newly registered patients at the practice had a health check, and this included babies and children.

The practice had a childhood immunisation protocol which had been recently updated with routine childhood immunisations. The practice was registered to provide the enhanced service for, Measles, Mumps and Rubella (MMR) catch up. Immunisation history was checked during the initial consultation and missing immunisations would then be discussed and offered.

A child protection policy and procedure were in place and staff were knowledgeable in this area. However, some GPs had not received the required level of child protection training.

The practice had extended hours on certain days, and staff told us that appointments for children were often booked outside of normal working hours due to school hours and parents' work commitments. A children's play house was located in the practice gardens, and there were baby changing facilities inside the practice.

The practice was registered for the local enhanced service for chlamydia. Sexually transmitted diseases (STD) screening results were not given over the phone, and patients saw a practice nurse to discuss these results in person.

Working age people (and those recently retired)

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

Our findings

Patients could telephone, email or attend the practice in person to make an appointment as the practice website did not currently facilitate online appointment bookings. The practice was providing an enhanced service, extended hours, and patients had access to appointments outside of normal working hours. Appointments were available with the GPs on Tuesday till 18.00, Thursday till 17.30, and from 07.30 on Wednesday. The nurses offered appointments on Thursday till 19.00 and from 07.30 on Friday. Patients told us the GPs were available for telephone consultations if they could not get an appointment and appropriate advice would be given. Patients also found it useful that the GPs communicated via email.

All new patients were offered a consultation with the health care assistant and were not registered with the practice until they attended this check-up. We saw reminder letters which were sent to patients who failed to attend their appointment. Health issues identified during the check-up were escalated to a GP immediately if required. The practice also offered NHS health checks for patients aged 40-74.

The majority of patients were referred to Hillingdon Hospital, however if a patient requested to be seen at another hospital, the practice used the "Choose and Book" system to accommodate this. Repeat prescriptions could be requested in person, via e-mail, post, fax or by pharmacist request. The website did not currently facilitate online prescription requests.

There was an in-house smoking advisor who offered smoking cessation advice, and the health care assistant provided alcohol and drug screening. Health promotion literature was available both in the practice and on their website, and directed patients to further sources of information. The practice advertised their weekly 'healthy walk' activity in local newspapers to promote physical activity in the community.

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

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

Our findings

There was a vulnerable adult policy in place. Staff had received recent training and were knowledgeable in this area.

The practice was registered for the directed enhanced service, learning disability. 13 patients were identified as having learning disabilities and all of these patients had received their annual health check-up. The GPs we spoke with had knowledge of the Mental Capacity Act (2005) and were aware they may need to assess mental capacity when treating patients with learning disabilities.

The practice had identified carers and were aware of their needs. There was a carer's protocol in place, and referrals were made to social services for assessment when required.

People experiencing poor mental health

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

Our findings

The practice liaised with a mental health consultant to discuss patient referrals. Staff told us that the practice managed most mental health conditions in-house, however patients could be referred to the community mental health teams for assessment and brief treatment, long-term and enduring mental health problems, and acute psychosis.

Data from the Quality and Outcomes Framework (QOF), a system detailing GP practice achievement results, showed that the practice had not achieved the national average for the proportion of patients with serious mental health who were offered a physical health check. The GP principal informed us this was related to the absence of nursing staff the previous year and this had now been addressed by employing two practice nurses who were able to carry out the health checks.

The practice participated in the enhanced service, diagnosis and support for people with dementia. The GPs we spoke with had knowledge of the Mental Capacity Act (2005) and were aware they may need to assess mental capacity when treating patients with dementia. An example was when the pharmacist contacted the GP principal after a patient attended the pharmacy and appeared 'confused'. The GP principal saw the patient at the practice and made a referral to the memory clinic for specialist input and to confirm the diagnosis.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: The registered person did not, so far as reasonably practicable, ensure the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection. There was no infection prevention and control audit, and no Legionella risk assessment. Regulation 12(2)(a).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The registered person did not ensure that service users are protected against the risks of unsafe care or treatment arising from a lack of proper information by means of the maintenance of records in relation to the management of the regulated activity. There were no documented cleaning schedules in place. Reg 20(1)(b)(ii).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The registered person did not ensure that information specified in Schedule 3 is available in respect of a person

This section is primarily information for the provider

Compliance actions

employed for the purposes of carrying on a regulated activity. An enhanced criminal record certificate was not available for a practice nurse, and two administrative staff who carried out chaperone duties.

Regulation 21(b) Schedule 3(2)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including receiving appropriate training. Two GPs had not received Level 3 child protection training. Regulation 23(1)(a).