Isleworth Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This report presents the findings from our inspection of the Isleworth Centre. The practice is registered with the Care Quality Commission to provide primary care services. We carried out a comprehensive inspection on 20 November 2014. We spoke with patients, a member of the patient participation group (PPG), and staff including the management team.

The practice is rated as 'good' for providing a safe, effective, caring, responsive and well-led service. We gave the practice an overall rating of 'good'.

Our key findings were as follows:

- The practice had systems in place to record, monitor, review and address risks to patients. Staff understood and fulfilled their responsibilities to raise safety concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised to support development.
- The practice's focus was on improving patient outcomes, and the practice networked with other local providers to monitor performance and share best practice.
- Appraisals and personal development plans were undertaken for all staff, and staff received support to develop in their roles.
- Feedback from patients about their care and treatment was positive. There was a patient-centred culture where staff treated patients with kindness and respect.
- Areas identified by patients as requiring improvement, such as telephone access, were recognised by the practice and we found examples to demonstrate how patient feedback was valued and acted on. The practice actively reviewed complaints to identify any themes and learning.
- The practice understood the needs of the local population and services were planned to ensure these needs were met. There was flexibility for patients to book appointments at a time that suited them. The practice was open 08:00 – 21:00 every weekday, and 09:00 – 13:00 at the weekend.

Summary of findings

- Urgent appointments were available the same day, and longer appointments were available for people who needed them. A child emergency policy was in place where children under the age of five would be seen the same day after a discussion with the GP, and children under six months old were automatically booked in by reception staff to be seen the same day.
- Policies and procedures to govern activity were in place, and there were systems in place to monitor and improve quality and identify risk. There was a strong focus on learning and training, and staff described a culture of openness and support.

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

Importantly, the provider must:

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

The provider should:

- Provide chaperone training for staff who undertake these duties.
- Risk assess whether non-clinical staff require health-care associated infection prevention and control training.
- Ensure that both patient participation groups are able to contribute to the continuous improvement of the service.
- Improve signage directing patients around the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Opportunities for learning from internal and external incidents were maximised to support improvement, and learning was shared with staff. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe. Most risks to patients were assessed and well managed. However the practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) nor had undertaken a risk assessment of this.

Are services effective?

Good

The practice was rated as good for providing effective services. There were systems in place to ensure that national guidelines and other locally agreed guidelines were used to influence and improve patient outcomes. The practice regularly met with other health professionals to coordinate care, and networked with local providers to shared best practice. Clinical audits were undertaken on a regular basis and reflected areas relevant to the practice to improve the quality of services provided. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Appraisals and personal development plans were undertaken for all staff, and staff received support to develop in their roles.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was positive. Data showed patients rated their interactions with the GPs as higher than average, when compared to other practices in the local area. We observed a patient centred culture where staff treated patients with kindness and respect, and maintained confidentiality. All patients we spoke to said that staff treated them with dignity and respect. Patient feedback was less positive about the length of time it took to see the GP they preferred, and telephone access to the practice. The practice had taken into account feedback for improvement, and we found examples to demonstrate how people's choices and preferences were valued and acted on.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services. The needs of the practice population were understood and services

Summary of findings

were planned to ensure these needs were met. Patients said urgent appointments were available the same day, and they were very satisfied with the opening hours. Longer appointments were available for people who needed them. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from patients and the Isleworth practice patient participation group (PPG). However, a proportion of patients were not represented as the Grove PPG had not been consulted since the two practices merged.Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. There was an active review of complaints to identify themes and learning needs, and these were shared with staff.

Are services well-led?

Good

The practice was rated as good for being well-led. The practice had a clear vision and strategy which was to deliver high quality care and promote good outcomes for patients. The practice values were shared with staff and promoted during team meetings and away days. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. There was good leadership and a strong learning culture. The team used clinical audits, performance data, patient feedback, staff feedback, and practice meetings, to assess how well they delivered the service and made improvements where possible. There was an open and supportive culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. All staff had received regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice was rated as good for the care of older people. All patients over the age of 75 had a named GP and were informed of this in writing. The practice's appointment system allowed for longer appointment slots, telephone consultations, and home visits for patients over the age of 70. The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and unplanned admissions.Clinical risk meetings were held monthly to discuss older patients with complex needs, and the practice worked with other healthcare providers including district nurses to coordinate patient care. The practice also offered the flu and shingles vaccinations to older patients in line with current national guidelines.

People with long term conditions

Good

The practice was rated as good for the care of people with long term conditions. The practice conducted clinical audits which looked at the management of patients with long-term conditions, and changed their practice as a result. Patients who had a care plan were reviewed every three months, and longer appointment slots were booked for these reviews. The practice worked with other healthcare providers to coordinate patient care. Clinical risk meetings were held monthly to discuss patients with complex needs, including long-term conditions. The practice had a palliative care register and monthly clinical meetings, as well as quarterly multidisciplinary meetings, were held to discuss the care and support needs of these patients and their families. New patients registering with the practice were screened to identify if they were at risk, or had chronic disease or conditions requiring medicines. These patients were then followed up by the GPs or nurses. There were GP leads in specialist areas such as palliative care and dementia.

Families, children and young people

Good

The practice was rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children who were at risk, and child protection cases were reviewed with the health visitor every six weeks or sooner if required. There was a dedicated clinical lead for safeguarding children, and all staff had received relevant role-specific training in child protection. A new 'child emergency policy' was in place where children under the age of five were seen after a discussion with the GP, and children under six months old were automatically booked in

by reception staff. A good skill mix was noted amongst the GPs with many having additional diplomas in areas relevant to the needs of the local population, such as sexual and reproductive health, obstetrics and gynaecology, children's health, and family planning. Longer appointments were allocated for antenatal and postnatal checks, and childhood immunisations were carried out by the GPs and nurses. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice was rated as good for the care of 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. The practice was open 08:00 – 21:00 every weekday, and 09:00 – 13:00 at the weekend. Patients could book appointments online, over the phone, or in person, and emergency appointment slots were available daily. Text message reminders for appointments and practice updates were also utilised. Repeat prescriptions could be requested online, in person, via e-mail, post, or by pharmacy request. NHS health checks were offered to all patients between the ages of 40 and 74. This was an opportunity to discuss any concerns the patient had and identify early signs of medical conditions. GPs had additional diplomas in areas relevant to the needs of the local population, such as sexual and reproductive health, obstetrics and gynaecology, and family planning. Cervical smear tests were offered to patients in line with national guidelines. Travel vaccinations were administered at the practice, and health promotion material was also available to patients.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for the care of people whose circumstances may make them vulnerable. There was a system to highlight vulnerable patients. Care plans had been completed for 177 patients on an enhanced care list, and this list was reviewed regularly at practice meetings. The practice held a register of patients with learning disabilities, and longer appointments were offered to these patients. The practice had signed up to enhanced services for patients with learning disabilities, and had carried out annual health checks for these patients. There was a system in place for identifying carers, and these patients were offered health checks and immunisations. Referrals were also made so that carers could access further support, and a designated noticeboard in the practice provided carers with further information. There was a clinical lead for safeguarding vulnerable adults, and staff knew how to recognise

Summary of findings

signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including people with dementia). There was a GP lead for mental health, and longer appointment slots were available for patients with mental health conditions. New patients with mental health conditions were booked for a health check with the GP and nurse, and were offered further support in line with their needs. The practice made urgent referrals to secondary care mental health teams, and also utilised a pathway for patients with mental health issues who were not in crisis to be seen in primary care.

Summary of findings

What people who use the service say

We spoke with five patients and one member of the Isleworth patient participation group (PPG) during our inspection. We reviewed 17 CQC comment cards which had been completed by patients, data from the National GP Patient Survey 2014, a survey on access undertaken by the practice and Isleworth PPG, and two Friends and Family Tests done in April and July 2014.

Patients we spoke with were happy with the cleanliness of the environment and the facilities available. Patients said staff always treated them with dignity and respect. Patients rated their interactions with the GPs as higher than average, when compared to other practices in the local area. Some patients commented that telephone access to the practice was an issue, and the practice took action by conducting a survey on telephone access and making changes in response to this. All the patients we spoke with told us they were very satisfied with the opening hours since the two practices merged. The latest Friends and Family Test showed that 89% of patients who took the test would recommend the practice to their friends and family.

The comment cards reviewed were mostly positive and said staff were helpful in addressing patients' needs. Negative comments related to the length of time it took to receive a non-urgent appointment. There were two PPGs in place, however the practice had only consulted with one group since the merger.

Areas for improvement

Action the service MUST take to improve

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

Action the service SHOULD take to improve

- Provide chaperone training for staff who undertake these duties.
- Risk assess whether non-clinical staff require health-care associated infection prevention and control training.
- Ensure that both patient participation groups are able to contribute to the continuous improvement of the service.
- Improve signage directing patients around the practice.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, practice manager specialist advisor, and an expert by experience. They were granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to Isleworth Centre

Isleworth Practice and Grove Practice are two co-located GP surgeries based in the Isleworth Centre for Health. The practices have separate Alternative Provider Medical Services (APMS) contracts with NHS England for delivering primary care services to the local community. Although performance data is submitted separately, service provision and delivery is done collectively and they are registered with the Care Quality Commission as the Isleworth Centre ('the practice'). They are part of Greenbrook Healthcare, an NHS primary care provider, whose services include urgent care centres, walk-in centres, and GP practices.

The Isleworth Centre provides primary care services to around 9,600 patients living in the surrounding areas of Isleworth, in the London Borough of Hounslow. The Indices of Multiple Deprivation (2010) shows that Hounslow is the 92nd most deprived local authority (out of 326 local authorities, with the 1st being the most deprived). The practice has a higher proportion of patients between the ages of 25-45, when compared with the England average. The proportion of patients over the age of 60 is lower than the England average.

The practice has nine salaried GPs (two male, seven female) and a longstanding female GP locum. The number of sessions covered by the GPs equates to 5.6 whole time equivalent (WTE) staff. The number of sessions covered by the two nurses and two health care assistants equates to 1.6 WTE staff. The practice manager and business support manager are responsible for the day to day management of the service, and support the administrative team.

The practice shares the premises at Isleworth Centre for Health with other health care providers. It is open every weekday from 08:00 to 21:00, and weekends 09:00 to 13:00. Appointments must be booked in advance, and some emergency appointments are available daily. The practice also participates in a 'hub' service, which provides weekend access to a GP for patients in the locality. The practice has opted out of providing out-of-hours services to their own patients. Outside of normal opening hours patients are directed to the NHS 111 service.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

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.

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

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

We carried out an announced inspection on 20 November 2014. During our inspection we spoke with four GPs, including a clinical lead GP, the clinical director, and the medical director. We also spoke with one nurse, the director of nursing, a healthcare assistant, the practice support manager, the business manager, and four administrative staff. We observed how patients were being cared for and sought the views of patients. We spoke with five patients and one member of the Grove Practice patient participation group. We reviewed 17 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.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

Records were kept of significant events that had occurred and these were made available to us. Staff we spoke to were aware of their responsibilities to raise concerns, and the procedures for reporting incidents and significant events. We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff used a template on the practice intranet and sent completed forms to the lead GP and the provider for reviewing. All incidents were systematically logged with details of the event, outcome, actions required, and progress update. We reviewed the system used to manage and monitor incidents, and saw records were completed in a comprehensive and timely manner. Open incidents were filed separately for ease of access. The reported incident summary showed there were 33 incidents reported this year, of which 23 were closed and 10 remained open and under review. The 10 incidents which remained open since May 2014 had the initial outcome recorded, and the practice regularly updated the log with further action that had been taken or was required. For example, speaking with the CCG, or the need for a review of a policy at the next practice meeting. From the incidents that were closed we saw evidence of the action taken as a result, for example there was a delay in processing a referral which had been returned by the referral facilitation service as it had not been signed by the GP. The practice had discussed the incident at the clinical risk meeting and the outcome was for returned referrals to be given to the on-call GP to triage. The practice had reviewed reported incidents and categorised them under themes, for example there were six incidents relating to referrals, and four relating to repeat prescriptions.

Significant events were a standing item at the monthly practice meetings, which were attended by all GPs, the practice manager, and the lead receptionist. There was evidence that the practice had learned from these and that the findings were shared with all staff.

Patient safety alerts were printed for relevant staff members who were required to sign and confirm they had read the alert. These were then scanned by the administration team and logged, and copies that were not signed were followed up with the relevant staff member.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had received the necessary training to enable them to fulfil this role, for example Level 3 child protection training. If the leads were not available, the on-call doctor was the next point of contact. All other staff had received relevant role specific training on safeguarding. For example, we saw evidence of recent in-house safeguarding training provided for administrative staff. Staff were required to complete a post-training assessment and achieve a minimum score to pass the module. The practice carried out annual safeguarding training for all staff, and we saw the training presentations for the last three years. We asked members of the administrative team about their recent training, and all staff knew how to recognise signs of abuse and how to escalate a safeguarding concern within the practice.

The practice had separate policies for child protection and safeguarding vulnerable adults. There were procedures for escalating concerns to the relevant protection agencies and their contact details were accessible to staff. The contact details for the local safeguarding teams were recorded in a folder at reception, and all the staff we spoke with were aware of this.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

A chaperone policy was in place and signs informing patients about this service were visible in consultation

rooms. There was no chaperone training for staff, and some non-clinical staff members were sometimes unclear about the role, for example the importance of being able to observe the examination.

Medicines management

Arrangements were in place to ensure medicines were stored securely and only accessible to authorised staff. There were clear procedures for ensuring that medicines were kept at the required temperatures, and staff were able to describe the action to take in the event of a potential failure. Fridge temperatures were checked by the practice nurses twice a day and we saw up-to-date logs to confirm this for the two fridges where medicines were stored. Emergency drugs were checked monthly by the nursing team and records confirmed these checks were up-to-date. We checked a random selection of vaccinations and medicines in the treatment rooms and medicine fridges and found they were stored securely and were within their expiry date.

There was a lead GP for prescribing and they met regularly with a prescribing advisor from the Clinical Commissioning Group (CCG) to ensure prescribing was safe and effective. The prescribing lead conducted regular reviews of prescribing and made practical suggestions for change when required. For example, the lead had monitored spending on prescribing and worked closely with the CCG pharmacist to replace some medicines with appropriate equivalents. We saw evidence that the lead shared information on prescribing with colleagues during the monthly practice meetings.

Repeat prescriptions could be requested online, in person, via e-mail, post, or by pharmacy request. It was the practice's policy not to accept orders over the phone for safety reasons, except in emergencies or for housebound patients. Prescriptions for dosette boxes were completed to help patients, for example the elderly, manage their medicines. The practice was preparing to adopt electronic prescribing, which allows prescriptions to be sent electronically to a pharmacy of the patient's choice. A GP told us this would help synchronise repeat prescribing dates for patients taking multiple medicines and make the prescribing and dispensing process more convenient for patients. It was the practice's policy to process repeat prescriptions within 48 hours of a request being made. Administrative staff generated authorised repeat prescriptions. Most repeat prescriptions required reviewing after two months with the exception of medicines for contraception and long term conditions, where prescriptions were reviewed after six months. The GPs told us longer prescriptions were issued after the patient's condition had been reviewed and remained stable whilst taking the medicine for a period of time. Blank prescription forms were stored securely at all times.

There was a system in place for the management of patients taking high risk medicines such as methotrexate and warfarin. The practice had access to the hospital laboratory to confirm these patients had received the relevant blood tests before a prescription was issued or authorised.

Vaccines were administered by the nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant was also able to administer the flu vaccine under patient specific directions.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Notices reminding staff of good hand hygiene techniques were displayed by hand washing sinks, along with soap, hand gel and hand towel dispensers. Disposable curtains were available around the examination couches in the treatment rooms, and we saw these had been changed in September 2014.

The practice lead for infection prevention and control was a practice nurse, and the deputy lead was the health care assistant. We were told that only clinical staff were required to undergo training in infection control, and we saw evidence that this was monitored by the practice. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves and aprons were available for staff to use and nursing staff were able to describe how they would use these to comply with the practice's infection control policy. Procedures for needle stick injury were displayed in treatment rooms and also documented within the infection control policy.

The most recent infection control audit, carried out in September 2014, had not identified any improvements for action. We saw there were cleaning schedules in place and

cleaning records were kept. Clinical waste was managed by the nursing staff and was locked away in a secure area. The premises underwent a yearly 'deep clean', which had taken place within the last 12 months. The maintenance company for the building had also carried out a legionella risk assessment in 2012, which was due for renewal in December 2014.

Equipment

Staff told us they had sufficient equipment to carry out their roles in assessing and treating patients. Equipment had been tested and calibrated in November 2014, and we saw records to confirm this for items such as blood pressure monitors and weighing scales. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was March 2014.

Staffing and recruitment

The practice had recruitment policies that set out the standards it followed when recruiting clinical and non-clinical staff. Recruitment checks were undertaken for new staff prior to employment, and these included proof of identification, two references, qualifications, registration with the appropriate professional body, and a criminal records check via the Disclosure and Barring Service (DBS) for all clinical staff and non-clinical staff acting as chaperones. We reviewed a selection of recruitment files and saw evidence that appropriate recruitment checks had been undertaken prior to employment.

All new staff underwent a general induction, which covered mandatory training such as safeguarding and basic life support. Further role specific induction was also provided, for example, the induction for new reception staff included training on confidentiality, consent, and the appointment system. An electronic copy of the staff handbook was available for staff to access.

The practice planned and monitored the number and mix of staff required to meet patients' needs. A rota system was in place to ensure there were enough clinical and non-clinical staff on duty. Senior staff had identified that the practice manager required support with the daily running of the service and as a result a new practice manager was due to start work the following month. The practice had also identified the need for more nursing staff, and we saw recruitment checks had been completed for two new nurses who were currently undergoing role specific training with the provider.

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. There was a health and safety policy which formed part of the induction process for all new members of staff. The employee handbook also contained general health and safety information for staff.

The building's management were responsible for maintenance of the premises, and the practice showed us evidence of the most recent safety checks undertaken. For example, we saw checks on the water system, fire alarm system, and emergency lighting had been conducted this year. There was also annual and monthly risk assessments for the environment. The practice manager told us that if there were any maintenance issues which required addressing, they would call the building's management and document this in a communication book. We saw evidence that recent issues had been logged and resolved, such as changing lights in the waiting room and fixing a soap dispenser unit.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available, including access to medical oxygen. The practice did not have an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency) and had not undertaken a risk assessment with regards to the absence of an AED. Emergency medicines were available in a secure area of the practice. These included those for the treatment of cardiac emergencies, anaphylaxis and hypoglycaemia. It was the responsibility of the nursing staff to check that emergency equipment and medicines were within their expiry date and suitable for use, and we saw records to confirm monthly checks were taking place. All the medicines we checked were in date and fit for use, and all staff knew of their location.

A 'disaster handling and business recovery plan' was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Risks identified included access to the building, loss of computer and telephone systems, and incapacity of staff. A copy of the document was kept off the premises by senior

Good

Are services safe?

management and the practice manager, where it could be accessible in the event of an emergency. The plan contained relevant contact details for staff to refer to, such as contact details for the maintenance company in the event of failure to the electricity, gas or water supply.

Records showed a fire risk assessment had been conducted by the premises management in January 2014, and fire alarms were tested on a weekly basis. The lead receptionist was the fire marshal for the practice and had completed training to carry out this role. Other staff were aware of the practice's procedures to follow in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and the Medicines and Healthcare Products Regulatory Agency (MHRA) around treatment and prescribing. The practice also received regular updates from the Clinical Commissioning Group (CCG). Staff told us that new guidelines and updates were shared with the team during practice meetings. We saw minutes to confirm that prescribing advice from the CCG had been discussed at a recent practice meeting.

The provider ran monthly clinical risk meetings which were attended by the clinical leads and the practice manager from six of the Greenbrook Healthcare GP practices. The practice GPs also attended CCG meetings, and monthly locality meetings with other practices in the area. The purpose of these meetings was to discuss clinical cases, current best practice in primary care, and updates relevant to the local area. Attendance at these meetings was rotated between the 10 GPs, and relevant information was then shared at practice meetings.

The GPs told us they led in specialist areas such as mental health, palliative care, dementia and prescribing. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example, the GPs told us they supported staff to review and discuss care plans for patients identified as at 'high risk'. Our review of the clinical meeting minutes confirmed that this happened.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. An example of a Clinical Commissioning Group (CCG) led clinical audit included insulin prescribing for patients with type 2 diabetes, where the results were used to confirm if GPs were prescribing in line with NICE guidance. Another clinical audit looked at patients with diabetes who had elevated HbA1c (a blood test which indicates average blood glucose over the previous 2-3 months). The practice also conducted other non-clinical audits such as reviewing outpatient referrals where the patient was referred back to the practice, and a home visit audit to ensure relevant information relating to home visit requests was documented appropriately. The practice showed us seven audits that had been undertaken in the last year. These audits were not complete as the second cycles, to assess if performance had improved, were due the following year.

The GPs told us clinical audits were often linked to medicines management information or safety alerts. For example, an audit to review the use of a medicine was conducted following new guidance from the MHRA regarding the long-term safety of the medicine. The information was shared with all GPs so they could carry out reviews for patients who were prescribed this medicine. Patients were then contacted and their prescription was stopped or changed to an alternative medicine in line with the guidelines.

The practice had a palliative care register with five patients receiving end of life care. Patients on the palliative care register were given longer appointments to discuss their care plans. The practice had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We reviewed meeting minutes where the palliative care nurse attended and palliative care patients were discussed.

The practice participated in local benchmarking run by the CCG, within their locality network, and with other Greenbrook Healthcare practices. Benchmarking is a process of evaluating performance data from the practice and comparing it to similar surgeries. Monthly reports on prescribing, accident and emergency attendance, and referral patterns were reviewed by the clinical leads and shared with the team during practice meetings. We saw the practice had completed care plans for 2% of their most vulnerable patients, in line with the requirements for the unplanned admission enhanced service. The practice was now working towards their internally set target to complete 2.5% of care plans for their most vulnerable patients.

The practice used the information they collected for the quality and outcomes framework (QOF), a national performance measurement tool, to monitor outcomes for patients. Last year (2013/14) the Isleworth practice achieved 820/900 points and the Grove practice achieved 591/900 points as part of the QOF. We spoke to senior management about the differences in achievement between the two practices, and they informed us that they

Good

Are services effective?

(for example, treatment is effective)

took over the Grove practice in December 2013 and therefore the Grove results were not a full year QOF score. They told us that service provision was shared between the two practices and all patients received the same level of care regardless of which practice they had initially registered with.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed a selection of staff training records and saw that staff were up to date with attending mandatory courses such as basic life support, child protection, and safeguarding vulnerable adults. We saw refresher courses had been booked with external agencies for next year so that staff could maintain their professional development.

A good skill mix was noted amongst the GPs with many having additional diplomas in areas relevant to the needs of the local population, such as sexual and reproductive health, obstetrics and gynaecology, children's health, and family planning. We reviewed a selection of the GPs' training files and saw they were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). All GPs underwent an additional annual appraisal with the practice, and we saw five out of 10 GPs had received their practice appraisal this year. This included an analysis of clinical consultations to review practice in areas such as prescribing, documentation quality, and appropriate examinations.

The practice nurse was undergoing additional training to become a nurse practitioner. We saw the nurse and one health care assistant had received their annual appraisal, and the other health care assistant was due for appraisal next year. The practice had identified a need for more nursing staff and had recruited two nurses who were undergoing training, specific to primary care, which was offered by the provider. They were due to start work in 2015. Locum staff did not undergo appraisal with the practice, however they had regular supervision from the clinical leads and during practice meetings. All clinical and non-clinical staff received annual appraisals which identified areas for personal development and action plans on how these would be achieved.

Working with colleagues and other services

The practice worked with other healthcare providers to coordinate patient care. Clinical risk meetings were held monthly to discuss patients with complex needs, including older patients, and patients with long-term conditions. Every quarter these meetings were attended by a multidisciplinary team including palliative care nurses and district nurses. Open and new child protection cases and safeguarding concerns were discussed with the health visitor every six weeks. It was the responsibility of one of the clinical leads to maintain regular contact with the health visitor to arrange meetings, and discuss urgent cases which may have arisen between scheduled meetings.

The practice had a good working relationship with other services located within the health centre, such as the community response service which had a multidisciplinary team including GPs, physiotherapists, social workers, and occupational therapists. The practice also made referrals to a smoking cessation service that was located at the centre.

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. These were shared equally between the GPs, including the on-call doctor for review. The reviewing GP was responsible for carrying out any follow-up actions. It was the practice's protocol to review patients who had been discharged from hospital within three working days of receiving notification, and staff told us this could be done over the phone, in person, or by home visit. Staff we spoke with understood their roles.

Care plans had been completed for 177 patients on an enhanced care list, and this list was reviewed regularly at practice meetings. Patients who had a care plan were reviewed every three months, and longer appointment slots were booked for these reviews. If these patients had been discharged from hospital, their care plan was reviewed by the clinical leads to learn whether the admission might have been avoided and to make any appropriate changes to the patient's on-going care.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

Clinical staff were responsible for their own referrals and letters, and electronic systems were in place for making these referrals. All referrals were sent to the Referral Facilitation Service (RFS), with the exception of urgent two week wait referrals for conditions such as cancer. The practice had reviewed their referral rates which were historically high, and encouraged GPs to discuss cases if they were uncertain about the referral pathways. They were currently reviewing rejected referrals from the RFS by clinical topic, such as gynaecology, to see if there was a learning need in the practice.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as hospital discharge letters, to be saved in the system for future reference. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Patients were made aware of this via the practice website.

The practice participated in a 'Hub' service which provided weekend access to a GP for all patients in the locality. Staff told us that most practices in Hounslow used the same electronic patient record system, and GPs could access these records during consultations. If records were not accessible, the patient would be temporarily registered and the record of the consultations sent to their own GP.

Consent to care and treatment

Staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. The practice kept a register of all patients with learning disabilities and since April 2014, all 16 patients had received their annual physical health check. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. One example was where capacity to make a decision about taking a medicine was an issue for a patient with learning disabilities. The practice arranged 'best interests' meetings with a learning disability consultant, and this was repeated at monthly intervals for six months with the social worker. The outcome was that the patient accepted the medicine. This highlighted how the patient was supported to make their own decision. 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).

Health promotion and prevention

The practice met 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. The practice offered NHS Health Checks to all its patients aged 40-75, and this was led by the nurse. Practice data showed the uptake was low, with 61 patients in this age group taking up the offer of the health check since April 2014. The practice were aware of this and planned to increase the capacity for NHS Health Checks by allowing the health care assistant to lead the process so that the nurse could focus on chronic disease management.

All new patients were requested to complete a health questionnaire at registration. These questionnaires were screened to identify if a patient was at risk, such as those with chronic disease, mental health conditions, or patients requiring medicines. The GPs were informed of all health concerns detected and these were followed up by booking the patient for a health check with the GP or nurse.

Clinical staff provided opportunistic health promotion advice during consultations, for example offering dietary advice and exercise promotion. The practice made referrals to a smoking cessation service that was located at the centre. The practice also used risk stratification to identify patients with diabetes and heart disease from ethnic groups where there was a high prevalence of these conditions. Risk stratification is a process to target specific patient groups and enable clinicians to offer appropriate interventions. These patients were contacted by the health care assistant for blood tests and a health check. The reception room had some health promotion information

Good

Are services effective?

(for example, treatment is effective)

on display, and there was a well-stocked area of leaflets available to patients in the communal foyer. We noticed some literature was outdated and notified the practice of this.

The practice offered personalised care to meet the needs of older patients and patients whose circumstances may make them vulnerable, and had a range of enhanced services, for example, in dementia, unplanned admissions, and learning disability health checks. There were nine patients who lived in sheltered accommodation, and they were seen in the practice by one of the GPs who had an interest in cognitive problems and dementia. Similar mechanisms of identifying 'at risk' groups were used for patients with mental health conditions and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's current performance for cervical smear uptake was 92.2% for Isleworth and 74.5% for Grove, with a target of 80% by April 2015. The practice also offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Out of 1733 patients aged six months to 65 years in the defined influenza clinical risk groups, 45% (783) had received their flu vaccination. This was an increase from last year's (2013/14) uptake of 34%. Last year the practice had also provided the flu vaccination to 56% of patients aged 65 and older. The practice manager was responsible for monitoring patients who did not attend screening or vaccinations, including patients who were due for their cervical smear test, the flu vaccination, or shingles vaccination. The recall process consisted of three reminders being sent to the patient in the form of text messages and letters. We saw records to confirm the practice was adhering to this process.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey 2014, a survey on access undertaken by the practice and Isleworth patient participation group (PPG) in February 2014, and two Friends and Family Tests done in April and July 2014.

These surveys found that patients reported being treated with dignity, compassion and respect by clinical staff. For instance, the National GP Patient Survey showed the practice was above the Clinical Commissioning Group (CCG) average for patient satisfaction on consultations with the GPs. Eighty-nine per cent of respondents said the GP was good at listening to them, compared with the lower CCG average of 83%. Seventy-eight per cent said the GP was good at treating them with care and concern, compared with the CCG value of 76%. The National GP Patient Survey showed that satisfaction scores on consultations with the nurses were comparable to the regional CCG averages. Seventy-three per cent of respondents said the nurse was good at listening to them, and 71% said the nurse treated them with care and concern. Feedback from the practice's Friends and Family Test showed that in May 2014, 83% of patients who took part in the test would recommend the service to their friends and family, and this figure increased to 89% in the follow-up test carried out in July 2014.

There were areas of the National GP Patient Survey where the practice was rated lower than the regional average. For example, 50% per cent of respondents said they got to see their preferred GP, compared with the CCG average of 56%. Patients raised this same issue when we spoke to them, with some stating they had waited two to four weeks to see a GP of their choice. The practice were aware that it may take a longer time for patients to see the GP they preferred, and were monitoring this to see if the increased opening hours had improved the situation.

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

The National GP Patient Survey 2014 showed that 25% of respondents were not happy with the level of privacy when speaking to receptionists, which was comparable to the regional average. Patients we spoke to raised this issue and said when they spoke to staff at the reception desk they could potentially be overheard by patients in the foyer area and waiting room. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located in a separate room behind the reception desk which also helped keep patient information private. Staff told us if a patient requested to speak with them in confidence they could access a private room. However, patients we spoke with were not aware of this and we did not see any notices informing patients about it.

We received 17 CQC comments cards where patients shared their views and experiences of the service. The majority of comments were positive. Patients said staff were polite, helpful and took the time to understand their needs. Comments which were less positive were about the time it took to receive a non-urgent appointment, and the length of time waiting to be seen at the practice. We also spoke with five patients, and one member of the Grove Practice PPG. They all spoke positively about the care they had received at the practice, and said their dignity was always respected.

Care planning and involvement in decisions about care and treatment

Information from the National GP Patient Survey showed patients responses were similar to the regional average for questions relating to their involvement in planning and making decisions about their care and treatment. Data revealed 69% of respondents found their GP was good at involving them in decisions about their care, and 77% felt the GP was good at explaining tests and treatments. Results for the same interactions with nursing staff showed 61% of respondents said the nurse was good at involving them in decisions about their care, which was the same as the CCG average. Seventy-four per cent said the nurse was good at explaining tests and treatments, which was higher than the CCG average of 70%.

Good

Are services caring?

Patients we spoke to 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. One patient told us that when they had more than one condition to discuss, they were given a double appointment which provided extra time for them to make an informed decision about the choice of treatment.

Translation services were available for patients who did not have English as a first language, and staff told us that this service had to be pre-booked up to one week prior to the patient's appointment. One patient we spoke with had an interpreter present, and said it was usually easy to book one through the practice. Staff were also able to speak other languages including Hindi, Punjabi, Arabic and Gujarati.

Patient/carer support to cope emotionally with care and treatment

There was a system in place for identifying carers and the practice currently had 40 patients registered as carers. Staff were aware of patients' needs and told us that carers were offered health checks and immunisations. Referrals were also made to external organisations and charities so that carers could access further support and information which may be relevant to them, for example bereavement services and end of life care. A designated noticeboard in the foyer provided information for carers to ensure they understood the various avenues of support available to them. The practice also made referrals to emotional support services, such as Improving Access to Psychological Therapies (IAPT), who were based within the same building.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the needs and challenges facing the practice population, and services were planned to ensure these needs were met. The nurse monitored patients with long-term conditions, such as diabetes, asthma, chronic obstructive pulmonary disorder, hypertension, and coronary heart disease. The administrative team managed the recalls of these patients and they were booked in for a consultation with extra time allocated to carry out the review. New patients who had been identified as having a mental health condition were put on to the mental health register. All patients on the mental health register were offered an appointment with the nurse for blood tests followed by a consultation with a GP.

The GPs and senior management engaged regularly with the Clinical Commissioning Group (CCG) and the locality network of GPs to discuss local needs and service improvement. We saw minutes of practice meetings where this information had been shared and discussed with staff. For example, a pathway for patients who presented with mental health issues but who were not in crisis and did not require secondary care was discussed at the most recent practice meeting.

The practice was commissioned for the 'unplanned admissions' enhanced service and had processes in place to reduce accident and emergency attendances. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice reviewed all accident and emergency and urgent care letters to track people who had care plans in place, and frequent attenders. Patients were contacted to discuss the reason for attendance, and those with care plans were reviewed upon discharge from hospital. If the attendance at accident and emergency was inappropriate or during practice opening hours, this was discussed with patients. We saw minutes to confirm how the practice was managing the care of a patient who frequently attended the out-of-hours service.

Clinical risk meetings were held monthly to discuss patients with complex needs, including older patients, and patients with long-term conditions. Every quarter these meetings were attended by palliative care nurses and district nurses, to discuss patients in receipt of palliative care and those with co-morbidities. Child protection cases and safeguarding concerns were discussed with the health visitor every six weeks.

Patients could access a male or female GP. All patients had a named GP upon registering, and patients over 75 years old were sent a letter notifying them of their named GP. Routine appointments with the GPs were 10 minutes, and the practice offered double appointments for patients who might require them, including patients with learning disabilities, mental health conditions, and multiple long-term conditions. Antenatal and postnatal appointments were also allocated additional time. Home visits and telephone consultations were available to patients who required them, including housebound patients and older patients.

The nursing staff had created various templates to be used by reception staff, and the booking system was flexible and allowed for these templates to be added to the electronic record. The template notified staff of the time required for the appointment, and also provided prompts to ask the patient. For example, reminding the patient to bring their inhaler to their asthma review, or reminding a parent to bring their child's immunisation book for the appointment. We saw templates had been created for asthma reviews, chronic obstructive pulmonary disease reviews, spirometry, ear syringing, childhood vaccinations, and flu vaccinations.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The National GP Patient Survey showed 73% of respondents found it easy to get through to the surgery by phone, which was slightly higher than the local CCG average of 70%. However, this was not reflected in feedback from the PPG who highlighted telephone access as an issue. The practice took action by advertising the booking of appointments online to reduce the volume of calls to reception, diverting incoming calls to other telephone lines during busy periods, and appointing more staff to answer calls at busier times. Patients we spoke with had telephoned the practice to make their appointment and told us they occasionally had difficulty getting through to the practice on the phone.

Tackling inequity and promoting equality

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice understood the needs of different groups of people to deliver care in a way that met these needs and promoted equality. For example, carers were offered health checks and there was also a designated noticeboard which provided information specifically for carers. The practice also had access to an interpreting service, and some members of staff spoke languages other than English. Patients commented that staff were receptive and attended to their needs.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. There was lift access to the first floor. Accessible toilets were also available.

There was an automated check-in screen to allow patients to check themselves in for an appointment, or patients could also approach the reception desk. The waiting room was separate to the reception area, and there was an electronic board to notify patients that the clinician they were seeing was ready. A few patients told us they found it difficult to locate consultation rooms and that signs directing patients could be improved.

Access to the service

Services were delivered in a way to ensure flexibility, choice and continuity of care. The practice was open 08:00 – 21:00 every weekday, and 09:00 – 13:00 at the weekend. Outside of normal practice hours patients were directed to an out-of-hours service. Patients could book appointments up to four weeks in advance, online, over the phone, or in person. A number of emergency appointments were available each day, and patients were required to telephone the practice as early as possible to book these. Information about appointments was available to patients in the practice, on the website and in the practice leaflet. Text message reminders for appointments and practice updates were utilised.

Patients confirmed that they could see a GP on the same day if they were in urgent need of treatment, and understood that they may not see the GP of their choice in these circumstances. Patients told us that since the Isleworth and Grove practices merged, they were very satisfied with the opening hours.

A new child emergency policy was in place where children under the age of five would be seen the same day after a discussion with the GP, and children under six months old were automatically booked in by reception staff to be seen the same day. Staff we spoke with were aware of the new policy for booking in children.

Longer appointments were available for people who needed them, including patients with multiple conditions, and patients with learning disabilities. Home visits and telephone consultations were made available to patients who needed one, including housebound patients and older patients. The practice's home visit protocol had been reviewed and discussed during a practice meeting in May 2014, and as a result staff were to ensure that patients' key safe numbers as well as next of kin details were updated for all home visits.

In addition to the weekend opening hours, the practice participated in a 'Hub' service which provided weekend access to a GP for all patients in the locality. Patients would contact the out-of-hours service where the call was triaged and the patient would then be referred to the hub if appropriate. The location of the hub rotated between the five GP practices participating in the service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager and business manager were the designated staff who handled all complaints in the practice.

We reviewed the 28 complaints received in the last 18 months and found these had been investigated and responded to in a timely manner. There was an active review of complaints, how they were managed, the action taken and how learning was implemented. The practice also conducted an annual review of complaints to identify themes and areas for improvement. For example, two complaints related to referral issues and the practice had looked into ways of improving their referral system. Staff told us that complaints received were discussed during practice meetings to ensure all staff were able to learn and contribute to determining any improvements that may be required, and we saw records to confirm this. All the staff we spoke with were aware of the system in place to deal with complaints, and that feedback was welcomed by the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice and seen as a way to improve the service. Staff told us they would try to diffuse any complaints, and if that did not resolve the issue, direct patients to the practice manager.

We saw that information on the complaints system was made available to patients in the practice leaflet and on the website. Further posters requesting feedback from patients were also on display. On the day of inspection, patients we spoke with were not aware of the process to follow if they wished to make a complaint. However, most patients told us they would speak to the receptionists or GPs if they needed to make a complaint about the practice.

The practice also conducted reviews of feedback received via the NHS Choices website. Comments were monitored and responded to, and the practice further analysed the themes that arose. This was then shared with staff in a quarterly newsletter to highlight the positive feedback received, and areas for learning. For example, staff were reminded of customer service skills to improve communication with patients over the phone.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. They had documented their mission statement and values, and these were made available to staff on the intranet. The practice's overall mission statement was to provide quality NHS care and put patients first. The values included: putting patients first; improving the quality of services by learning from successes and mistakes; maintaining integrity by being open, honest and respectful; providing a safe and efficient clinical service; communicating and listening; and good teamwork within the practice team and across organisational boundaries.

Staff we spoke with were aware of the practice values and knew what their responsibilities were in relation to these. We saw that the regular staff meetings and the practice away day helped to ensure that the vision and values were being upheld within the practice. The practice had yet to display their mission statement and values for patients to view.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practice intranet. All the policies we looked at had been reviewed and were up to date. There was a quality and governance manager and a clinical governance lead in place. The practice discussed clinical governance during the monthly clinical risk meetings, which were held with the four other local GP practices run by the provider. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

There were two clinical leads for the practice, and a clear leadership structure with named members of staff undertaking lead roles in other areas. For example, there were leads for safeguarding vulnerable adults, safeguarding children, and infection control. We spoke with 13 members of clinical and non-clinical staff and they were all clear about their own roles and responsibilities. They told us they felt supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. They recognised the differences between the Isleworth practice and the Grove practice and were seeking ways to improve the performance for both. We saw minutes to confirm that changes to QOF and enhanced services were discussed at monthly team meetings.

The practice conducted clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit on patients with diabetes recommended that follow-up arrangements could be improved, and patient education should be enhanced to achieve better outcomes. The practice planned to re-audit the following year once the recommendations were implemented. We considered that as some GPs had been revalidated audit cycles would have been completed. We did not however see evidence of this on the day, though we did see evidence of on-going audits.

The practice was involved in a peer review system to measure its service against the other five Greenbrook Healthcare GP practices. We looked at the review of the Friends and Family Test conducted in July 2014, and saw that the practice had received the second highest score of 89% (lowest scoring practice 65%, highest scoring practice 91%).

The practice had arrangements for identifying, recording and managing risks. There was a risk register, which had a description of the risk, the risk level, mitigating actions, and actions pending. For example, the lack of nursing cover was addressed by recruiting two nurses who would undergo further training in practice nursing. Health and safety and fire safety risk assessments were undertaken by the building's management.

Leadership, openness and transparency

We saw from minutes that whole practice meetings were held every four-six weeks, and meeting days were alternated to accommodate staff who worked part-time. Clinical risk meetings were held on a monthly basis with the other Greenbrook Healthcare GP practices, and we saw from minutes that outstanding actions from previous meetings were reviewed at subsequent meetings. Quarterly nurse meetings were conducted by the director of nursing and were available to all Greenbrook Healthcare nurses. Reception staff met every month with the practice manager, however these were informal discussions and were not documented. Staff told us they had the opportunity to raise issues at the meetings.

Are services well-led?

Good

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

We were shown the electronic staff handbook that was available to all staff, and included sections on equality and harassment at work, and whistleblowing. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, Friends and Family Tests, the National GP Patient Survey, NHS Choices and complaints received. We looked at the results of the most recent patient survey and saw that 30% of patients were not satisfied with telephone access to the practice. We saw as a result of this the practice advertised online appointment bookings, diverted calls to other telephone lines during busy periods, and appointed more staff to answer calls at busier times.

The practice had two patient participation groups (PPG) which represented the individual practices of Isleworth and Grove prior to the merger. The last meeting with the Isleworth practice PPG was in March 2014, however the practice had yet to merge the two PPGs. We spoke with a member of the Grove PPG who said he had not attended meetings this year as the combined PPG had yet to be formed. We spoke to the senior management team regarding this and they were aware that the Grove PPG had not received much contact since the merger. They told us that this was partly due to the challenges they faced joining the two practices on one site. As a result an additional practice manager, whose responsibilities would include managing the two PPGs, had been successfully recruited and was due to start the following month.

We saw the practice was conducting a pilot of clinical supervision sessions which involved clinical staff (GPs, Nurses, HCA) discussing cases studies. The practice requested anonymous feedback from staff regarding the sessions so that they could be reviewed and improved. We also noted that team away days took place and staff were encouraged to provide feedback on what was going well, and areas for improvement. Action points were developed following discussions with the whole team. The practice generally gathered feedback from staff through practice meetings, discussions, and appraisals. Staff told us they could give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. For example, the practice nurse was undertaking an independent prescriber course as part of her advanced nurse practitioner degree, and the director of nursing and the practice supported her to do this. The practice away days also offered clinical and non-clinical staff training sessions relevant to their roles. We looked at staff files and saw regular appraisals, which included a personal development plan, took place annually. The GPs also received an annual appraisal from the practice.

There were quarterly meetings for all Greenbrook Healthcare practice nurses, HCAs, and bank nurses. These meetings covered clinical topics, and significant events relevant to nursing staff. The director of nursing told us that recruiting nurses with experience in general practice had been difficult in the area, and the provider decided to offer courses for experienced nurses to train them as practice nurses.

The practice had completed reviews of significant events and other incidents, and these had been shared with staff during practice meetings. The GPs told us that when they went on courses they would feedback their learning to the practice during the clinical risk meetings. There was evidence of learning taking place during meetings to ensure the practice improved outcomes for patients.