Orchard Practice

Quality Report

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

Contents

Summary of findings

Overall summary

Orchard Practice is situated at 52 Station Road, Hayes, Middlesex and provides primary medical services to 4872 patients in the Hayes area.

During our inspection on 28 August 2014 we spoke with one male GP, a practice nurse, the health care assistant, the practice manager and three non-clinical staff. We spoke with 15 patients including three patients who were members of the Patient Participation Group (PPG). We reviewed 32 completed Care Quality Commission (CQC) comment cards, the findings of the most recent patient experience survey carried out in 2013, NHS Choices feedback, information from NHS England, the Hillingdon Clinical Commissioning Group (CCG) and Healthwatch UK.

We found the practice was safe, effective, caring, responsive and well-led.

Systems were in place to ensure safety incidents and alerts were reported and acted upon and to ensure the environment was safe for patients and staff. Medicines were managed safely and staff were trained to respond to medical emergencies.

Safeguarding procedures were in place to protect patients from harm. Most staff were aware of the practices' safeguarding procedures and had received training in safeguarding children and vulnerable adults. There was a whistleblowing policy in place and staff were aware of whistleblowing procedures.

Appropriate pre-employment checks had been completed for staff prior to their employment to ensure they were of suitable character to work at the practice.

Patients received effective care by staff who had received adequate training and professional development. Clinical audit and Quality and Outcomes Framework (QOF) data were used to drive practice performance and improve outcomes for patients. The practice worked closely with other health care professionals to deliver effective care to patients with complex needs.

The practice was caring. All the patients we spoke with and CQC comment cards we received were positive. Patients said the practice staff were professional and the service provided met their needs. Patients said the clinical staff provided a personalised service and involved them in decisions relating to their care and treatment.

The practice planned and developed services to meet the needs of the patients it served. Patients said there was good access to the service including a range of appointments, emergency slots, home visits and telephone consultations.

Governance arrangements were in place and staff were clear about their roles and level of responsibility. The practice engaged staff through regular meetings and staff worked as a team. Feedback was sought from patients through the Patient Participation Group (PPG) and patient experience surveys. Patients' comments and concerns were fedback to the practice by the PPG chair and acted upon. Complaints were listened to and responded to in a timely manner. However there was no action plan in place to improve the service based on the most recent patient experience survey carried out in 2013.

The practice met the needs of different population groups. For example care planning for older patients, patients with long term conditions and patients with learning disabilities. At the time of our inspection the practice had developed care plans for 24 patients with chronic obstructive pulmonary disease (COPD), 142 patients with diabetes and 26 patients with a learning disability. The practice offered a wide range of treatment and support for patients in vulnerable circumstances.

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?

Procedures were in place to ensure significant events were reported, analysed and learning shared with staff to reduce the likelihood of reoccurrence. Systems were in place to ensure safety alerts received from the NHS were distributed to the appropriate staff and acted upon. Medicines were managed safely and staff were trained to deal with medical emergencies.

Safeguarding procedures were in place to protect children and vulnerable adults from harm. However although clinical staff were knowledgeable on safeguarding both children and vulnerable adults reception staff were not clear on recognising the signs of abuse in adults and had not completed safeguarding vulnerable adult training. The practice manager was aware of this and had booked the reception staff onto a course. There was a whistleblowing policy in place and staff were aware of whistleblowing procedures.

The practice was clean and hygienic. Infection prevention and control procedures were followed by staff and systems were in place to monitor infection control standards.

Systems were in place to monitor risk including risk assessments for fire, general health and safety and audits for infection prevention and control. Where risks had been identified control measures were in place to minimise them. Equipment used by the practice had undergone regular safety checks.

Appropriate pre-employment checks had been carried out on staff before they started working for the practice to ensure they were of suitable character.

Are services effective?

Best practice standards and guidance were used to inform care and treatment and ensure patients received high quality evidence based care including guidance from the National Institute for Health and Care Excellence (NICE), legislation such as the Mental Capacity Act 2005 and professional publications such as the British Medical Journal (BMJ).

The practice participated in clinical audits to drive service improvement and provide best practice care and treatment. The results of clinical audit had been acted upon. The practice had scored positively in their Quality and Outcomes Framework (QOF) performance for the previous two years and used QOF performance to improve services for patients.

Summary of findings

The practice fostered close working relationships with other organisations and healthcare professionals. GPs attended regular multi-disciplinary team meetings to plan more in depth care and treatment for patients with complex needs.

Staff had received induction training when they started working for the practice, mandatory training in a wide variety of topics and annual appraisals to monitor their performance and identify any development needs. GPs were up to date with the revalidation requirements of the General Medical Council (GMC).

Are services caring?

We spoke with 12 patients during our inspection and received 32 completed Care Quality Commission (CQC) comment cards. All the feedback we received was very positive. Patients said the practice staff were kind, considerate and empathic towards them. They spoke highly of the clinical staff and they were happy with the care and treatment provided.

Patients said that staff involved them in decisions about their care and treatment. Patients said that they were treated with dignity and respect and consent was always sought before carrying out any physical examinations. Medical records were stored confidentially and consultations with patients were held in private.

The practice worked with counselling and support services to support patients going through bereavement.

Are services responsive to people's needs?

The practice had planned services to meet the needs of the local population including multi-disciplinary team work to improve outcomes for patients with complex needs and proactive management of patients with long term conditions.

The appointment system met patients needs. Patients were able to book an appointment in person or over the telephone and emergency slots were available when they needed one. Telephone advice was available daily and home visits provided for patients who were housebound.

The practice had a system in place for handling concerns and complaints. Patients' concerns were fedback to the practice by the Patient Participation Group (PPG) chair and acted upon. Complaints had been resolved in line with the practices' complaints policy.

Are services well-led?

The practice had clear leadership and governance arrangements in place. Staff were clear on their level of responsibility and who to

Summary of findings

report to with any issues. The practice had a mission statement in place and staff were able to articulate some of the core values of the practice. A business development plan was in place with key priorities to be achieved by 2015.

Systems were in place to monitor the quality of services provided including the analysis of significant events and clinical audit. The practice had an active Patient Participation Group (PPG) and regular patient surveys were carried out to gain patients views of the practice. The practice monitored comments from patients on the NHS Choices website and responded to negative feedback. However there was no action plan in place to improve services based on the most recent patient experience survey carried out in 2013.

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 practice provided services for older people. Care plans had been developed for 61 patients and patients over 75 years had a named GP in line with NHS requirements. There was a practice base healthcare coordinator who worked with the GPs to identify patients with complex needs and multi-disciplinary team meetings were attended to plan their care. Information was available on local charities offering care and support for older patients.

People with long-term conditions
The practice provided services to patients with long term conditions. The practice had developed care plans for 24 patients with chronic obstructive pulmonary disease (COPD) and 142 care plans for patients with diabetes. All patients with more than one long term condition had a care plan in place and care plans were reviewed regularly to ensure patients continued to receive care that met their needs.

Mothers, babies, children and young people
The practice provided services for mothers, babies, children and young people including antenatal and postnatal clinics, baby checks and child immunisations. The practice provided health promotion advice including advice on pregnancy planning and child health. Sexual health advice was available for young people.

The working-age population and those recently retired
The practice provided services for working age people and those recently retired. Services included extended surgery hours on a Tuesday for patients to make an appointment outside of normal working hours and cervical screening for females between 25 and 64 years. A wide range of health advice was also available for this population group.

People in vulnerable circumstances who may have poor access to primary care
The practice provided treatment and support to people in vulnerable circumstances who may have poor access to primary care. The practice was accessible to patients with no fixed abode and those who were homeless. Regular health checks were available for victims of trafficking and they were referred to primary care counselling services offering further support. The practice had an

Summary of findings

open access policy for patients with learning disabilities and had developed care plans for 26 patients. The practice treated patients who were vulnerable to substance misuse and worked with other organisations to deliver effective care.	
People experiencing poor mental health The practice supported patients experiencing poor mental health including regular health checks and links to other support organisations. The practice worked with carers and relatives in line with the Mental Capacity Act 2005 to assess patients mental health and make best interest decisions where appropriate.	

Summary of findings

What people who use the service say

We spoke with 12 patients during the course of our inspection and spoke with three members of the Patient Participation Group (PPG) including the PPG chair. We reviewed 32 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service, the NHS Choices website, the practices' most recent patient experience survey carried out in 2013 and the national patient survey 2013.

All the patients we spoke with and the CQC comment cards received were positive about the practice and staff. Patients said the services provided met their needs and all staff were professional and treated them with respect. The results of the patient experience survey showed that 78 percent of the 184 patients who participated rated the practice as good, very good or excellent. We also found that seven out of ten comments about the practice posted on the NHS Choices website were positive and the practice had received a four out of five star rating based on these. The results of the national patient survey 2013 were not so positive with 63 percent of patients saying they would not recommend the surgery to others. However response rate to the survey was low with only 26 percent of patients responding.

Areas for improvement

Action the service SHOULD take to improve

Identify areas for improvement and implement an action plan based on the 2013 patient experience survey.

Orchard Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. It included a GP, a practice manager, an expert-by-experience and a pharmacy inspector. They were all granted the same authority to enter Orchard Practice as the CQC inspector.

Background to Orchard Practice

Orchard Practice is a GP practice located in Hayes in the London borough of Hillingdon and operates from HESA Primary Care Centre, 52 Station Road, Hayes, Middlesex, UB3 4DD. The practice provides primary care services to 4872 patients in the local area. The practice is part of the NHS Hillingdon Clinical Commissioning group (CCG) which is made up of 48 GP practices. The staff comprise of one male GP, one female GP, two practice nurses, a healthcare assistant, a practice manager and a small team of non-clinical staff. The practice was established in 2004 and in 2011 became a non profit organisation social enterprise Community Interest Company (CIC) operated by a board of directors comprising of two GPs and two nurses working at the practice.

The practice opening hours are 8.00am to 6.30pm Monday to Friday with extended hours on Tuesdays from 6.30pm to 7.30pm. The practice provides a wide range of services including checks for blood pressure and diabetes, asthma and chronic obstructive pulmonary disease (COPD) reviews, cervical smears, antenatal and child health care, vaccinations and immunisations and family planning. The practice also provides help with smoking cessation, losing weight, healthy eating and lifestyle. The practice has opted out of providing out-of-hours services.

The age range of patients is predominantly 30-50 years. The practice serves a high immigrant population with over 50 percent of patients being of Somali origin.

Why we carried out this inspection

We inspected this out-of-hours 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 visiting, we reviewed a range of information we hold about the practice including information from NHS choices and national patient surveys and asked other organisations such as Healthwatch, NHS England and NHS Hillingdon Clinical commissioning Group to share what they knew about the service. We carried out an announced visit on 28 August 2014. During our visit we spoke with a range of staff including a GP, a nurse, the health care assistant, the practice manager, three non-clinical staff and spoke with 12 patients who used the service. We reviewed 32 completed Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe patient care

The practice had a system in place for reporting, recording and monitoring significant events and the procedures were followed by staff. Staff had received mandatory training in incident reporting and the training was updated annually. Procedures were in place to ensure safety alerts received from the NHS were distributed to the appropriate staff and acted upon.

Learning from incidents

We reviewed four significant events reported over the previous 12 months. The details of each incident had been recorded and action agreed to prevent reoccurrence. For example a nurse had not recorded on a child's medical record an immunisation given. The error had been corrected and training was provided to the nurse to ensure the incident did not reoccur. Another significant event we reviewed involved an aggressive and abusive patient. The incident was dealt with in line with the practice policy and staff were reminded to use panic buttons to alert other staff members. We saw evidence that significant events were discussed in staff meetings to ensure learning was shared.

Safeguarding

Policies and procedures were in place for protecting both children and adults from harm. Clinical staff had completed child protection training to Level 3 and non-clinical staff to Level 2. Clinical staff had also completed training in safeguarding vulnerable adults. Safeguarding issues were a topic discussed in monthly practice meetings and were attended by the health visitor and local school nurse. Clinical staff were knowledgeable about recognising the signs of abuse and they were able to describe the reporting procedures if they had any suspicions of abuse happening. However, two reception staff were not clear on recognising the signs of abuse in adults and they had not completed safeguarding vulnerable adults training. The practice manager was aware of this and showed us evidence that the two reception staff had been booked on a course to rectify the shortfall. A whistleblowing policy was in place and staff were aware of whistleblowing procedures.

Monitoring safety and responding to risk

Processes were in place for monitoring safety and responding to risk. The practice had commissioned an external company to carry out a fire risk assessment and a health and safety risk assessment. Both risk assessments had been completed in June 2014. Where risks had been identified control measures were in place to minimise them. Plans were in place to manage staff shortages including the use of a locum agency to cover staff absence due to illness or annual leave.

The practice had a business continuity plan in place which identified potential risk to patients including foreseeable emergencies such as IT failures and disruption to the facilities due to flood or fire.

Medicines management

Medicines were managed safely. Records confirmed that vaccines, immunisations and emergency medicines and other equipment including the emergency oxygen cylinder, defibrillator and nebulisers were checked regularly by the lead nurse to ensure they were in date and fit for purpose. Fridge temperatures were monitored daily to ensure vaccines were stored within the correct temperature range. Controlled drugs were stored in a locked cupboard and prescription pads stored securely in a locked room and the key held safely at reception.

Cleanliness and infection control

We found that the premises including both clinical and non-clinical areas were clean and hygienic. There was a plentiful supply of soap, hand gel and paper towels in the clinical areas of the practice. The practice held a contract with an external cleaning company and was cleaned on a daily basis. A cleaning rota was in place which was followed by cleaning staff. An inoculation injury poster was displayed as a quick reference for staff and clinical waste was disposed of by a professional waste company.

An infection control policy was in place. The practice nurses shared the lead on infection control to ensure the policy was followed by all staff. Staff had completed training on infection prevention and control and it was a topic of learning at practice meetings. The practice monitored infection control standards through regular infection control audits. We reviewed an audit completed in April 2014. Where risks were identified remedial action had been taken to mitigate them. For example it was identified that reusable personal protective equipment (PPE) posed a risk if not disinfected thoroughly after use. To mitigate the risk the practice replaced reusable PPE with single use equipment. It was also identified that there was a lack of

Are services safe?

handwash posters displayed above sinks for staff to reference whilst washing their hands. To mitigate the risk handwash posters had been displayed above sinks to ensure staff followed the correct handwash technique.

A legionella risk assessment had been completed and we saw evidence that daily, weekly and monthly checks were carried out to ensure the risks associated with legionella bacteria were minimised.

Staffing and recruitment

We reviewed six staff files including four clinical staff and two non-clinical staff. We found that all the necessary pre-employment checks were in place. These included references from previous employers, professional registration and Disclosure and Barring Service (DBS) checks. This ensured staff were of suitable character to work for the practice. We also found that staff had completed induction training when they started working for the practice and a recruitment policy was in place.

Dealing with Emergencies

Staff had completed training in responding to medical emergencies. This included cardiopulmonary resuscitation (CPR) and defibrillator training for all staff and anaphylaxis management for clinical staff. The training had been completed in the previous year and was due for renewal in October 2014.

Staff had received basic fire training and fire marshal training to ensure staff and patients could be evacuated safely in the event of a fire.

Equipment

The practice was well equipped with medical equipment that was fit for purpose. We viewed records which showed that all medical equipment had received calibration checks in the previous 12 months. Equipment included spirometers, thermometers, weighing scales and electrocardiogram (ECG) leads. We also saw evidence that other essential equipment such as fire extinguishers and fire alarms were regularly checked and serviced. PAT (portable appliance) testing of all portable electrical equipment was completed annually.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

Best practice standards and guidance were used to inform care and treatment and ensure patients received high quality evidence based care. For example GPs used the National Institute for Health and Care Excellence (NICE) guidelines to treat patients with long term conditions. Conditions included chronic obstructive pulmonary disorder (COPD), asthma, diabetes and cardiovascular disease. NICE guidance was discussed in clinical meetings to ensure best practice was shared. GPs used the British Medical Journal online to update knowledge. GPs also used current legislation such as the Mental Capacity Act 2005 to carry out mental capacity assessments and make best interest decisions for patients who lacked capacity. For example we saw examples of Do Not Attempt Resuscitation (DNARs) forms completed by GPs and completed mental capacity assessments required by the Court of Protection when family members of patients had applied to manage their relatives affairs.

Management, monitoring and improving outcomes for people

The Practice has a system in place for carrying out clinical audits. Examples of clinical audits included a wide range of prescribing audits carried out in conjunction with the Hillingdon Clinical Commissioning Groups (CCG) medicines management Local Enhanced Service. For example the practice had carried out audits of asthma medication and dressings for wound healing. Patients had been identified with these conditions and their prescriptions reviewed to ensure medication was being prescribed safely and effectively. There was evidence of the practice monitoring patients medications to ensure they were prescribed in accordance with NICE guidelines. However we did not see evidence of re-auditing to monitor the effectiveness of improvements made.

The practice had scored positively in their Quality and Outcomes Framework (QOF) performance in the previous two years. The QOF is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. The QOF covers for domains; clinical, organisational, patient experience and additional services.

Clinical areas where the practice had performed well included the management of asthma, diabetes and coronary heart disease, blood pressure monitoring and obesity.

Staffing

One male GP, one female GP and two practice nurses worked at the practice. A locum agency was used to cover absent GPs and nurses to ensure patients' needs were met. We reviewed six staff files including four clinical staff and two non-clinical staff. They demonstrated that staff had the appropriate skills and qualifications to meet patients' needs. The GPs were licenced by the General Medical Council (GMC) and the nurses registered with the Nursing and Midwifery Council (NMC). Both practice nurses had advanced qualifications and were nurse prescribers. Staff had completed induction training when they started working for the practice and received regular mandatory training in a variety of topics including basic fire awareness, equality and diversity, emergency life support, child protection, safeguarding adults, infection control, information governance and health and safety.

All staff had completed annual appraisals and staff told us they were actively encouraged to develop and contribute to their personal development plans. GPs were up to date with the General Medical Council (GMC) requirement for revalidation. One GP had completed revalidation in June 2014 and the second GP was not due to revalidate until April 2016.

Working with other services

The practice fostered close working relationships with other organisations and healthcare professionals. GPs attended monthly multi-disciplinary team meetings to plan more in depth care and treatment for patients with complex needs. Professionals attending the meetings included GPs from the practice, geriatric consultants, the community matron, mental health consultants, social services, medication management team and the palliative care team. GPs attended regular cluster meetings involving eight practices in the local area to compare data and improve outcomes for patients. Topics compared included referrals to secondary care, prescribing data and accident and emergency attendances. To reduce accident and emergency admissions of asthma patients the practice had purchased two nebulisers to treat patients at the practice. The practice worked with a health care coordinator and community matron to develop and manage care plans for

Are services effective?

(for example, treatment is effective)

patients who were housebound. The health care co-ordinator and community matron attended monthly clinical meetings at the practice and gave feedback to the GPs about patients care plans and the progress made in meeting their needs. At the time of our inspection the practice had care plans in place for 61 older patients. The practice used online systems for sharing information about patients with other services including information from the out-of-hours service, pathology tests and discharge letters.

Health, promotion and prevention

All new patients were offered a health check with the health care assistant (HCA) and were referred to a GP for a consultation if required. The HCA also provided a smoking cessation service. At the time of our inspection the practice was carrying out an audit to assess the effectiveness of the service however the results were not yet available. Other services included weekly cervical smear clinics for females between 25 and 64 years, advice on losing weight, healthy eating and lifestyle. As a result of the introduction of a weekly smear clinic uptake had improved by two percent in the previous year. The practice website provided information about a variety of conditions and treatments such as prostate cancer, breast cancer and cervical screening and also provided information on sexual health, eating well and exercise. The practice nurses offered a travel vaccination service and the practice website provided information on the vaccination requirements for a wide range of countries. The practice also offered childhood immunisation and vaccination services. The practice had identified a low uptake of measles, mumps and rubella (MMR) vaccinations. To improve uptake patients refusing MMR vaccinations due to this were given an extended appointment with the GP who provided parents with information and statistics showing MMR vaccinations were safe. We were informed this had improved uptake however data was not available to substantiate this.

A wide variety of information was available for patients in the waiting area of the practice. Information ranged from health promotion leaflets to support service contact details. Practice staff spoke a range of languages to help patients whose first language was not English with decisions about their care and treatment. Languages included Somali, Hindi, Arabic and Dutch. Fact sheets on the UK health services were available on the practice website in 21 different languages to assist new arrivals to the UK to find the necessary information to access health care and make informed decisions abut their health.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 12 patients during our inspection and reviewed 32 completed Care Quality Commission (CQC) comment cards. All the feedback we received about the practice was very positive. Patients said the reception staff were always friendly and treated them with respect, compassion and empathy. Patients praised the GPs who they said always engaged with them and provided a personalised service. Patients said they had developed a positive relationship with all staff and were usually called by their first names. This was reflected in feedback on the NHS Choices website where all the comments were positive over the previous 12 months. The results of the National Patient Survey 2013 were not so positive with only 63% of patients saying they would recommend the surgery to others. However response rate to the survey was low with only 26 percent of patients surveyed responding.

Although the practice had no specific support structure in place for bereaved patients, they said they did signpost patients experiencing bereavement or other concerns to local counselling/support services. The practice also offered an 'open house' if patients wanted to talk to someone and patients confirmed the practice staff were always there for them.

Patients privacy was respected during consultations and their medical records stored confidentially. The practice scored above the CCG average in the National Patient Survey 2013 for patient satisfaction in terms of the level of privacy when speaking to receptionists at the surgery. A chaperone service was available on request for patients who requested a third party present during a medical examination. Both clinical and non-clinical staff acted as chaperones and Disclosure and Barring Service (DBS) checks had been completed on them.

Involvement in decisions and consent

GPs sought consent from patients before they carried out physical examinations. The GPs understood Gillick competency and Fraser guidelines and used them to decide if a child is mature enough to make decisions relating to their care and treatment. Patients had a choice of either a male or female GP when booking appointments. Patients said the care received at the practice was always good and the GPs involved them in decisions about their care and treatment. They said the GPs were engaging and discussed the advantages and disadvantages of different treatments. However the practice scored below the CCG average in the National Patient Survey 2013 for patients with a preferred GP being able to see that GP and scored below the CCG average for how well GPs explained tests and treatments to them.

The practice worked with mental health professionals and relatives of patients to make best interest decisions in line with the Mental Capacity Act 2005. We saw examples of the involvement of GPs in best interest decisions relating to patients who lacked capacity.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice demonstrated awareness of the needs of the local population including arrangements for multi-disciplinary team working to meet patients needs. For example the practice had identified a high incidence of diabetes in the local population and in collaboration with other health care professionals had developed care plans to improve outcomes for patients with this condition. At the time of our inspection 142 care plans had been developed. The practice had developed a health promotion service targeted at the local Somali population. The practice was being proactive in its approach to work with the community regarding the dangers of drug misuse.

The practice responded to feedback from patients to the Patient Participation Group (PPG). The PPG chair attended practice board meetings and gave feedback concerns raised by patients. For example a patient had complained the practice were not at times empathetic enough. The PPG chair offered to be available in the waiting area two days per week as a point of call for patients with any issues and would bring these forward to the practice. The board agreed the idea and it was implemented.

The practice catered for patients with mobility needs including wheelchair access to the practice and modified toilet facilities. The practice worked with the Disablement Association Hillingdon (DASH), a charity providing support for disabled patients to be independent and lead an active life.

Access to the service

The practice opening hours were 8.00am to 6.30pm Monday to Friday with extended hours on Tuesdays from 6.30pm to 7.30pm. Appointments were bookable over the telephone or in person and they were available up to two weeks in advance. Telephone consultations were available on request with clinical staff and home visits available for patients who were housebound. Patients told us that emergency appointments were always available and most of the time on the same day requested. The practice also operated a waiting list for cancellations and during our inspection we observed reception staff telephone a patient offering them an appointment due to a cancellation. The practice also provided a text message service to remind patients of their appointments. The results of the national patient survey 2013 showed that only 59 percent of patients surveyed rated their experience of making an appointment as good or very good. However none of the patients we spoke with or the CQC comment cards we reviewed highlighted any concerns with booking appointments and feedback on the NHS Choices website in the previous 12 months was positive.

An out-of-hours doctors service was available for patients who needed a GP when the practice was closed and the contact telephone number was advertised on the practice website and in the practice leaflet. Repeat prescriptions were available within 48 hours. An electronic prescription service was available and patients were pro-actively encouraged to use it. Blood test results were available daily between the hours of 11.00am and 3.30pm. There was no online appointment booking system at the time of our inspection however plans were in place to implement this.

Meeting people's needs

Patients said they were provided with choice of referral to secondary care or specialist health care services. They said that referrals were made promptly and that they were provided with an explanation of the reasons for the referral. The practice secretary told us that referrals were processed via 'choose and book' a national electronic referral service allowing patients a choice of place, date and time for their appointment in a hospital or clinic. If a patient required an interpreter this would be communicated to the hospital who would arrange this.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice had received six complaints in the previous 12 months. All complaints had been acknowledged, investigated and resolved in line with the practices' complaints procedure. Staff were able to demonstrate an understanding of the practices complaints policy and procedures and complaints were a standard agenda item in staff meetings and learning from them was shared.

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

As a non profit organisation social enterprise Community Interest Company (CIC) the practice was operated by a board of directors which comprised of clinical staff who worked at the practice. The practice had developed a mission statement which was "to provide a high standard of professional patient relationship, a whole system approach of care providing patients with the tools to develop a healthy future." The practice staff were able to articulate some of the core values of the practice which were openness, fairness, respect, accountability, integrity, empathy and compassion. The practice had a business development plan in place with clear objectives to be achieved by 2015. The objectives included improvements to patient services based on local population needs, increased staffing levels where funds allowed, further development of the practice website and plans to provide an out-of-hours service in collaboration with other local practices.

Governance arrangements

Staff had clear roles and responsibilities. The two practice nurses shared responsibility for infection control and clinical governance and one nurse was responsible for safeguarding children and adults. The male GP was the clinical lead for the practice. Board meetings were held on a monthly basis where topics relating to the running of the practice were discussed and priorities agreed. The practice manager was responsible for the day to day running of the practice and attended board meetings. Both clinical and non-clinical staff were clear on their role and specific responsibilities.

Systems to monitor and improve quality and improvement

The practice monitored their QOF performance to improve services for patients. We saw evidence that QOF performance was discussed in monthly board meetings and areas for improvement highlighted. For example it was identified from the 2012-13 QOF results that there was a low cytology uptake. To improve this the practice opened a weekly smear clinic and advertised it in the waiting area. As a result the practice achieved a two percent increase in cytology uptake in the 2013-14 year. The practice participated in clinical audit and medication reviews to ensure patients received safe and effective care. There were audits of infection control and health and safety to ensure the environment was safe for patients, where risks had been identified measures had been put in place to mitigate them.

Patient experience and involvement

The practice had an active Patient Participation Group (PPG) comprising of 54 members to represent patients and feedback their views about the practice. The PPG chair was available at the practice reception two days per week as a point of contact for patients. Two members of the PPG were diabetes champions and offered healthy lifestyle information to patients and another member was a fitness professional who was planning to provide exercise sessions for wheelchair bound patients.

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

The practice had received ten comments on the NHS Choices website since December 2012. Seven out of ten comments were positive and where patients had commented negatively the practice had responded to their concerns. The practice had a comments and suggestions form on their website for patients to feedback and an active PPG. Issues raised with the PPG by patients were voiced to the practice at monthly board meetings and acted on. The practice had carried out an annual patient experience survey in November 2013. The results of the survey showed that 78% of the 184 patients who participated in the survey rated the practice positively. However although the survey documented feedback from patients there was no action plan in place improve services based on the survey. The practice sought the views of staff through monthly practice meetings and annual appraisal.

Staff engagement and involvement

Staff said they were valued as part of a team and were supported to carry out their job roles effectively. Clinical staff attended monthly meetings to discuss clinical topics such as Quality and Outcomes Framework (QOF) performance and medication issues. There were monthly practice meetings involving all staff covering topics such as significant events, safeguarding cases and infection control. Monthly administration meetings were held to discuss any issues with recording data.

Learning and improvement

There was an open learning culture within the practice and staff were encouraged to report incidents as they occurred.

Are services well-led?

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

There were systems in place to learn from significant events, complaints, feedback from surveys and audit. Learning was shared with all staff and improvements made to the services provided as a result.

Identification and management of risk

The practice had a business continuity plan in place to assess the potential risk to patients and ensure continuity of care in the event of a foreseeable disruption to the service. The plan had been reviewed annually.

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 practice provided services to older people. For example the practice had developed care plans for patients over 75 years to reduce unnecessary hospital admissions by ensuring their health needs were met. GPs worked with a health care coordinator based at the practice and the community matron. Patients were identified and called in to the practice for an assessment. The healthcare coordinator visited housebound patients and liaised with social services to meet their social care needs. At the time of our inspection 61 out of 70 patients identified for a care plan had one in place. The aim of the care plans was to provide the best standard of care to patients and reduce unnecessary emergency admissions to secondary care. Over 75's also had a named GP in line with NHS requirements.

The practice referred appropriate patients to Hillingdon carers, a local charity providing volunteer carers to help older people with their social care needs and age UK, a charity providing advice on care and support, financial matters and a telephone befriending service for older people.

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 provided services for people with a wide variety of long term conditions. These included asthma, diabetes, chronic obstructive pulmonary disorder (COPD), cardiovascular disease and kidney disease. The practice had started to develop care plans for patients with long term conditions in 2013. At the time of our inspection the practice had developed 24 care plans for patients diagnosed with COPD and 142 care plans for patients diagnosed with diabetes. All patients with more than one long term condition had a care plan in place. Care plans were reviewed every six months to ensure patients continued to receive effective care and treatment.

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 provided services to mothers, babies, children and young people including antenatal and postnatal clinics, checks for babies between six to eight weeks old and child immunisations. The practice also provided health promotion advice on the practice website including pregnancy planning and child health between 0 and 15 years. Sexual health advice was also available for young people. The practice prioritised children by making appointments available if requested before 10.00 am.

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

The practice provided services to working age people and those recently retired. These included cervical smear screening for females between 25 and 64 years and extended surgery hours on Tuesdays from 6.30pm to 7.30pm for patients requiring an appointment outside of normal working hours. A wide range of health promotion services were available including smoking cessation advice, help with losing weight, healthy eating and general lifestyle.

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

The practice provided treatment and support to people in vulnerable circumstances who may have poor access to primary care. For example the practice provided services to patients with no fixed abode and those who were homeless to ensure they had access to the same primary care services as the rest of the community. The practice had an agreement with a charity providing housing and support for vulnerable people. The practice provided regular health checks and reviews for these patients and referred them to the primary care counselling service for further support.

The practice provided treatment and support for patients with learning disabilities including annual health checks and provided services for two supported living homes. The practice had developed care plans for 26 patients and had an open access policy whereby they could walk in and see a GP without an appointment.

The practice operated a shared care scheme with Hillingdon Drug and Alcohol Service (HDAS). The aim of the scheme was to manage patients with drug addiction. At the time of our inspection there were 12 patients who received methadone treatment for drug addiction. A GP at the practice had received training in methadone prescribing and attended regular meetings with the Hillingdon drug and alcohol team. Support was also available for patients with drug and alcohol addiction on the practice website including information on a charity providing counselling, treatment and support services for substance misusers.

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 supported patients experiencing poor mental health by providing regular health checks for them. Information was available at the practice and on the practice website. This included links to charities such as Mind, the Mental Health Foundation and the Samaritans.

The practice carried out mental capacity assessments and where necessary worked with carers and relatives to make best interest decisions for patients who lacked capacity in line with the Mental Capacity Act 2005.