Doctors Shenton, Seddon & Sparrow

Quality Report

Maswell Park Health Centre
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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

We carried out an announced comprehensive inspection at Doctors Shenton, Seddon & Sparrow (also known as The Redwood Practice) on 11th November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should

- Implement a formalised policy for monitoring refrigerator temperatures including the responsible person.
- Ensure that documentation of reference checks are recorded in staff files.

Summary of findings

- Document outcomes and action plans from weekly business meetings.

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. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. For example, all significant events were recorded with relevant learning points and action plans to improve service. National patient safety alerts (NPSA) were disseminated electronically to relevant practice staff. Risks to patients were assessed and well managed. There was an infection control policy and regular complete cycle audits were performed to ensure it was followed. Staff had received role appropriate training in safeguarding children and vulnerable adults. The practice was equipped to manage medical emergencies and staff had received up to date training in basic life support. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice undertook clinical audit to drive improvement, for example Clinical Commissioning Group (CCG) led audit into unplanned hospital admissions. The practice participated in a CCG led external peer review of referrals to secondary care. Staff had received training appropriate to their roles and any further training needs were identified and planned to meet these needs. There was evidence of appraisals and/or personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with kindness, respect and compassion and they were involved in decisions about their care and treatment. The practice was above average in the Clinical Commissioning Group (CCG) area for its satisfaction scores on consultations with doctors from the National GP Survey 2014. Information in the waiting room was easy to understand and sign-posted patients to a number of support groups

Summary of findings

and organisations. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice maintained a list of patients who were carers and had an identified 'carers champion' a source of support and extra information for carers.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment, with urgent appointments available the same day. Feedback from the national GP survey 2014 was positive about the appointment system with 93% of respondents describing their experience of making an appointment as good. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice was accessible to wheelchair users. There was easy to understand information available to patients about the practice's complaints procedure. The practice maintained a record of all complaints received and showed evidence of learning from complaints and improvements to practice.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. The staff set yearly objectives for the practice for development and improvement, for example objectives for 2014 included topics such as domestic violence training staff and service expansion at the health centre. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and there was evidence of improvements to the service as a result of feedback from the PPG. Staff had received inductions, 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 is rated as good for the care of older people. GP's identified older patients who were high risk of hospital admission and implemented care plans to minimise this risk including proactive referral to support services such as community matron, care navigator and social services. The practice was part of one of five locality networks in Hounslow Clinical Commissioning Group (CCG)who met regularly to discuss and plan management for patients over 75 years age at risk of becoming unwell. GPs could refer patients to the Integrated Community Response Services (ICRS), which is a multi-disciplinary team of physiotherapists, occupational therapists and nurse assessors who review and support patients in the community. One of the GPs reviewed patients weekly in a local care home to provide health checks and prescription reviews.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Annual health checks were offered to patients with long term conditions and one of the GPs ran a call and re-call system for review of patients with diabetes. GP's identified patients with long term conditions who were high risk of hospital admission and implemented care plans to minimise this risk including proactive referral to support services such as community matron, care navigator and social services. The practice was part of one of five locality networks in Hounslow Clinical Commissioning Group (CCG)who met regularly to discuss and plan management for patients with diabetes at risk of becoming unwell. Some patients with Chronic Obstructive Pulmonary Disease (COPD) at high risk of admission were provided with 'rescue-pack' medications to take at home when they started to feel unwell. The practice had access to the community oxygen assessment team for patients who required oxygen therapy at home.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice nurses offered family planning and sexual health services including opportunistic chlamydia screening. There were twice weekly ante-natal services with the community midwife in attendance. The practice offered a full range of childhood immunisations in line with national guidance and uptake rates were in keeping with the Clinical Commissioning Group (CCG). One of the practice nurses had a specialist interest in teenage health and had

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attended a training course on managing diabetes in teenagers. The practice had a teenager's board and bulletin in the waiting area providing information targeting patients of this age group. There was a local refuge centre for woman and the practice provided medical care for woman staying there as needed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice offered extended hour appointments for patients who could not easily attend the practice during working hours. Appointments and repeat prescriptions could be requested online. The practice offered NHS Health Checks to patients aged 44–74 years. The practice nurse offered health checks to all new patients joining the practice, that included offering HIV finger prick tests to patients 18 years and over with same day referral to a local sexual health clinic if positive. All three practice nurses were level three trained smoking cessation counsellors.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice maintained a register of patients with learning disabilities and they were offered annual health checks with extended time appointments. The practice also kept a register of patients who were carers.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice offered annual health checks to patients experiencing poor mental health. GP's had access to refer patients to in house support services such as the Hounslow iHEAR drug and alcohol dependence service and Improving Access to Psychological (IAPT) counselling services. The practice maintained a list of patients with a diagnosis of dementia and receiving investigations for dementia.

Summary of findings

What people who use the service say

During our inspection we received 33 Care Quality Commission (CQC) comment cards that patients had completed and spoke with eight patients who used the service including six representatives from the practice patient participation group (PPG). Overall the feedback given was positive. Patients were satisfied with the care they received and felt that all staff at the practice were helpful, friendly, kind and caring. This was similar to the findings of the national GP patient survey published in July 2014 which found that 94% of respondents described their overall experience of the practice as good and 91% said that they would recommend the practice to someone new to the surgery.

Two of the 33 CQC comment cards completed described longer waits after appointment times being an occasional issue at the practice. This was highlighted in the national GP patient survey with 50% of respondents indicated a wait of 15 minutes or less after their appointment time to be seen, which was lower than the regional average.

Areas for improvement

Action the service SHOULD take to improve

- Implement a formalised policy for monitoring refrigerator temperatures including the responsible person.
- Ensure that documentation of reference checks are recorded in staff files.
- Document outcomes and action plans from weekly business meetings.

Doctors Shenton, Seddon & Sparrow

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 and a practice manager who were granted the same authority to enter the practice premises as the CQC inspector.

Background to Doctors Shenton, Seddon & Sparrow

Doctors Shenton, Seddon & Sparrow, also known as Redwood Practice is located in Maswell Park Health Centre in Hounslow and shares the premises with two other GP practices. The practice is part of the NHS Hounslow Clinical Commissioning Group (CCG) made up of 54 GP practices. The practice provides primary medical services through a Personal Medical Services (PMS) contract to approximately 6,000 patients in the local community. Minor surgery and an anti-coagulation monitoring service is commissioned through a Local Enhanced Services (LES) contract.

The practice has a predominately young patient demographic with the largest age distribution between 25 - 34 years of age. There is a wide ethnic mix that covers all social class groups in the practice population. There is a lower deprivation score for the practice population compared to local and national Clinical Commissioning Group (CCG) averages.

The practice team includes one male senior partner, two female partners and one female salaried long term locum GP. There are three female practice nurses shared between the three practices in the health centre and each covers a session at each practice on a rota basis. There is also a shared locum practice nurse for home visits and International Normalised Ratio (INR) testing and two shared health care assistants. The administration team comprises of a practice manager, two senior receptionists, four receptionists, one administrator and one secretary.

The practice is open from 7.00am to 6.30pm with further extended hours on Monday to 7.30pm. The practice has opted out of providing out-of-hours services to its own patients. The details of the out-of-hours service are communicated in a recorded message accessed by calling the practice when it is closed and on the practice website. The practice provides a variety of services including checks for diabetes, checks for heart disease, ante-natal services, family planning, child health care and minor surgery. The practice also provides health promotion services including flu vaccination programme, foreign travel vaccinations and cervical smear screening.

The Care Quality Commission (CQC) intelligent monitoring placed the practice in Band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a wide range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National GP 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.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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 visiting we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We met with NHS England, NHS Hounslow Clinical Commissioning Group (CCG) and Healthwatch Hounslow and reviewed the information they provided us with. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 11th November 2014.

During our visit we spoke with a range of staff including GPs, practice manager, practice nurse, reception and administration staff. We also spoke with eight patients who used the service including six representatives from the practice patient participation group (PPG). We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed policies and procedures, practice maintenance records, infection control audits, clinical audits, significant events records, staff recruitment and training records, meeting minutes and complaints. We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the days before our visit.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality to patient safety. For example, safety incidents, national patient safety alerts as well as comments and complaints from patients who used the service. Staff we spoke with were aware of the procedures to follow to report significant events and near misses. For example, a recent significant event of poor communication and documentation between community secondary services in the management of a patient had been reported with evidence of learning from the event documented. We reviewed incident reports from March 2013 to date and these demonstrated that safety incidents had been managed consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. For any significant event that occurred the staff member involved would complete a significant event record. These records included a description of the event, discussion of what went well, areas that could have been done better and then a discussion of learning and future development points. For example, a recent significant event record had been completed for a medical emergency that occurred in the waiting room when a patient became very unwell. Reflection on positive points from the event included prompt assessment, initial management and calling emergency services. However, it also highlighted the need for a review and adjustment of the process in place for the re-ordering of emergency drugs. The event was discussed with the practice team and learning and action points agreed.

National patient safety alerts were received electronically through a central alerting system and the information was disseminated by email or through the practices computer system messaging facility to relevant staff. We were shown an example of a safety alert received from NHS England relating to the Ebola virus disease for circulation.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a named GP lead for safeguarding children and vulnerable adults. The practice kept details for the named local authority lead for safeguarding children and adults. We reviewed training certificates in staff files. All GP's and nurse practitioners had received child protection training at level three, practice nurses at level two and health care assistants and administration staff at level one. Staff had completed safeguarding vulnerable adults training which included domestic violence, forced marriage and female genital mutilation. Staff we spoke with were aware of the potential signs of abuse, understood their responsibilities and the processes to follow for reporting any suspected cases of abuse.

The practice had a chaperone policy that set out guidelines for staff to follow for the protection of patients and staff from abuse or allegations of abuse. The policy was advertised in the practice newsletter. We were told that one of the practice nurse or a HCA acted as chaperones if required and they all had undertaken Disclosure Barring Service (DBS) checks, records were seen that confirmed this.

The practice had a whistle blowing policy to guide staff in the reporting of any suspected malpractice, failure or malfunction at the practice. This was also documented in the employee handbook. Staff we spoke with were aware of their responsibilities to disclose any issues or suspicion of concerns.

Medicines management

The practice had five clinical fridges where vaccinations and other injectable medicines were stored. There was a temperature record book kept for each fridge for the recording of daily fridge temperatures to ensure vaccines were stored at the required temperature. However, we noted that there had been a few occasions when fridge temperatures had not been recorded. Nursing staff were responsible for checking the fridge temperatures. When we brought this to their attention they correlated the blank recording days to when the nurse responsible had been off work. The practice did not have a written policy for monitoring fridge temperatures or protocol for the actions required if fridge temperatures fell outside the recommended range. Nursing staff we spoke with were aware of the processes to follow but acknowledged that this had not been formalised and needed to be.

A system was in place for the checking of vaccine and medicine expiry dates and stock was rotated to ensure older stock was used first. Vaccines were administered by qualified nursing staff and health care assistants using up

to date directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of patient group directions for vaccines administered by nursing staff. Directions for flu vaccines administered by health care assistants (HCA's) were signed by the practice GP's for individually named patients.

There was a GP lead in medicine prescribing. Patients could request repeat prescriptions in person and online if registered to do so. Processes were in place for the review of repeat prescribing which included a medicine review reminder at least annually but sooner if there was a change in medicine prescribed or medical need. Blank prescription forms were tracked through the practice and kept securely at all times.

The practice had a system for monitoring high risk medication such as anti-coagulants. A phlebotomist attended the practice every week day between 8.30am and 12.30pm to perform blood tests including International Normalised Ratio (INR) checks. The locum practice nurse shared by three practices in the health centre was also able to go to patient's homes and take blood for INR checks if they were unable to attend the practice due to illness or disability. The INR results were regularly monitored by GPs before prescriptions were issued.

Cleanliness and infection control

We observed the premises to be clean and tidy. Several of the Care Quality Commission (CQC) comment cards received praised the cleanliness of the practice. The practice had a lead for infection control and infection control protocols were in place. Infection control audits were regularly conducted with the last one completed in October 2014 with a compliance rate of 97%. There was evidence that the practice took action on recommendations made.

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

The practice had a well-equipped minor surgery room and there was a clear infection control process in place. The practice used single use instruments for all minor surgery they performed. We saw that an infection control and decontamination check list was used following each minor surgery procedure performed. This included an audit trail of all surgical waste including disposable single use instruments and specimens. All staff were up to date with required occupational health hepatitis B immunisations.

Disposable privacy curtains were used in all consultation and treatment rooms and were changed annually or whenever soiled. Children's toys were available in the treatment rooms and consulting rooms and we were told staff were responsible for cleaning toys in their own rooms.

An external contractor was responsible for the daily cleaning of the environment with a scheduled list of cleaning tasks. Weekly checks on standards of cleanliness were carried out by the premises management company. We reviewed the results from the most recent audit which showed the practice scored 96.9% only missing points on high level dusting. We were told a deep clean of the premises was performed annually, although we did not see evidence to confirm this. The cleaning cupboard was well stocked and equipped with all necessary materials. A risk assessment for the Control of Substances Hazardous to Health (COSHH) had been completed in September 2014. A legionella risk assessment had been completed in July 2014. Legionella is a germ found in the environment which can contaminate water systems in buildings.

Equipment

Staff we spoke with told us they had the equipment to enable them to carry out diagnostic examinations, assessment and treatment. Calibration checks on medical equipment was performed annually which we saw had last been tested in March 2014. We observed a lung function testing machine had not been checked at this time but we were informed by nursing staff that it was rarely used. The practice had a fire safety policy and fire alarms were tested weekly and calibrated bi-annually. We saw that fire extinguishers had been calibrated in January 2014 which we were told was an annual occurrence.

Good

Are services safe?

Staffing and recruitment

The practice had a recruitment policy and checklist in place for new starters. Review of staff records showed that all staff had received Criminal Records Bureau (CRB) or Disclosure and Baring Service (DBS) checks. There were few written references in the staff records and the practice manager told us that most of the staff had worked at the practice for many years and that verbal references had been taken. There was an employee handbook issued to new starters that included information on health and safety, whistle-blowing, disciplinary procedures, grievance procedure and equal opportunities procedure. There was a separate new employee's safety handbook that included information on health and safety and fire precautions that all new starters were required to sign to confirm they had read and understood the information given.

Staff told us they would cover for other members of the team if they were off sick or on annual leave to maintain safe staffing numbers. We saw the reception staff rota that ensured the reception was adequately staffed at all times.

The practice used locum doctors if required from a GP locum network. This service enabled the practice to access locum GP's relevant documents including GMC registration, employment history and references. An introduction booklet was provided to locum GP's when they worked at the practice which detailed the operational systems that were in place.

Monitoring safety and responding to risk

Processes were in place for monitoring safety and responding to risk. The shared premises were managed by an external company. They carried out regular checks on the building to ensure it was safe for patients, staff and visitors. The checks included Legionella risk assessment, health and safety risk assessments including fire safety, fire extinguisher checks, asbestos risk assessment and emergency lighting checks.

The practice had a health and safety policy that was available for all staff to refer to and was included in the employee's handbook.

We were told that staff were able to identify and respond to changing risks to patients including deterioration in health and medical emergencies. For example, there was a significant incident report detailing a recent occasion when the practice staff had to respond to a patient who became acutely unwell in the waiting room.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed all staff were up to date in basic life support training. The practice had an easily accessible resuscitation trolley equipped with defibrillator, oxygen and airway devices. However, it was noted there was no resuscitation equipment or oxygen in the minor surgery room although staff told us they were in the process of putting this in place. Emergency medicines were stored with the resuscitation equipment and included medicines for management of cardiac arrest, anaphylaxis, chest pain, seizures and asthma attacks. All emergency medicines were in date and expiry dates were checked weekly by the practice nurse.

The practice had a business continuity plan that could be retrieved from outside the building in the event that the building could not be accessed. The plan included key external contact details, immediate response and actions to be taken and emergency alternative temporary accommodation information.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP's and nursing staff were familiar with current best practice guidelines from the National Institute for Health and Care Excellence (NICE) and local commissioners. For example, staff told us the practice followed NICE guidance on prescribing and secondary care referrals. We were told new guidance was discussed at weekly business meetings and disseminated to relevant practice staff. There were no minutes available for these meetings but the practice manager showed us the agenda for these meetings. They did not routinely record outcomes or action plans as a result of these meetings.

There were GP leads in specialist areas such as chronic conditions, child health, minor surgery and women's and ante-natal health. The practice nurses were trained to support people with long term conditions such as asthma, high blood pressure and heart disease. Clinical staff we spoke with told us they were supportive of their colleagues and felt comfortable to ask for advice themselves.

Data from the Clinical Commissioning Group (CCG) showed the practice's performance for antibiotic prescribing was comparable to similar practices in the area. All referrals made to secondary care were reviewed by the Hounslow Referral Facilitation Service (RFS). The GPs received feedback about referrals made to monitor and improve the quality of referrals. The practice participated in a CCG led external peer review of referrals to secondary care with 11 other GP practices within the Heart of Hounslow locality network.

We saw no evidence of discrimination when making care and treatment decisions and that the culture in the practice was that patients were referred based on clinical need only.

Management, monitoring and improving outcomes for people

The practice undertook complete clinical audits to monitor and improve outcomes for patients. For example, a recent complete audit into inadequate cervical smear results between 2011 and 2013 looked at the factors that may be involved when a smear test performed gave inconclusive results. The results of this audit were discussed at a clinical policy meeting in February 2013 and action points were identified, that included in house further training for clinical staff performing smears. The practice also developed a policy that patients over the age of 45 attending for a repeat smear should be offered an appointment with one of the senior GPs to improve the chances of adequate smear testing. We saw evidence that clinical audit has been performed on insulin prescribing and missed hospital appointments with changes in practice as result.

Clinical audits were often linked to medicines management and as a result of information from the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, the practice carried out an audit of emergency admissions during October 2013. There were 22 admissions during this period and all were deemed appropriate. However, two admissions were identified to have benefited from an integrated care plan that may have prevented the admission. As a result of the audit the practice aimed to continue risk profiling the population and create integrated care plans for high risk patients. Similar audits were conducted for referral rates to secondary care and avoidable attendances to accident and emergency departments to identify trends.

The practice collected data QOF and their performance was used to monitor outcomes for patients. The practice had met all the standards for QOF in atrial fibrillation, high blood pressure, learning disabilities and osteoporosis and the majority of the standards in diabetes, asthma and kidney disease.

The practice had measures in place to identify and monitor patients at high risk of hospital admission to reduce unscheduled hospital attendances. For example, we were told GPs would identify patients at high risk of admission and then arrange review with the practice nurse to develop a care plan and ensure the correct community services were in place to support the patient at home. The practice could refer high risk patients to various community support services including community matron, care navigator and social services. The practice could also refer these patients to the Integrated Community Response Service (ICRS). This was a multi-disciplinary team, of physiotherapists, occupational therapists and nurse assessors who reviewed patients in the community to provide urgent assessment and acute medical intervention in order to avoid hospital admission. The practice also provided high risk patients

Good

Are services effective?

(for example, treatment is effective)

with Chronic Obstructive Pulmonary Disease (COPD) with 'rescue pack' medication to take if they became unwell at home. In this event patients were encouraged to telephone the GP for advice prior to attending accident and emergency to minimise hospital admissions.

Effective staffing

Practice staff included medical, nursing, managerial and administrative support staff. We reviewed staff training records and all staff were up to date with mandatory training courses such as basic life support. There was no training log available to show all staff training for the practice. We noted a good skill mix amongst the doctors with one doctor a level two qualified surgeon providing in-house and outreach clinics for minor surgery. The practice nurses had training to manage various specialist areas including diabetes, managing diabetes in teenagers, sexual health and family planning.

The practice GPs were up to date with their annual continuing professional development requirements. One of the GP partners had been revalidated and the other two GP partners had a date for their 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 practise and remain on the performers list with NHS England). Clinical staff received annual appraisal which included personal development plans to identify areas for training and improvement. The next appraisal for all clinical staff was due at the end of the year. Staff told us they felt supported to approach the GPs and management team to request additional training if needs were identified. The practice manager told us they spoke daily with the administration staff to discuss issues and any training needs and therefore did not perform annual appraisal. We were told any issues or training needs identified during these discussions were documented and followed up on. We saw evidence to confirm these discussions had taken place.

Working with colleagues and other services

The practice worked with a variety of multi-disciplinary teams including health visitors, midwives, district nurses and community matrons. There were no regular multi-disciplinary team meetings but we were told GPs would have discussions with these services as and when required.

The practice received information from other services including secondary care, out-of-hour services and pathology services electronically and by post. There was a pathology protocol for sending minor surgery specimens to the local pathology services. Results were sent electronically back to the practice from the pathology services for the attention of the doctor who had performed the procedure, who would explain the results to the patient.

Information sharing

Effective processes were in place for communicating with other providers. For example, information was received electronically and by post from out-of-hour and secondary care services. We were told the practice received 90% of hospital discharge letters electronically and the remainder by post. They were directed to the appropriate GP for action if required.

The local Urgent Care Centre (UCC) providing out of hours care connected to the same electronic patient record as that of the practice. This allowed clinical staff with permission to access patient's records when they attended the service and access to a patient's medical history when making decisions on treatment and care.

The practice had signed up to Summary Care Records (SCR) and we saw there was an information leaflet available for patients explaining what this was and how to opt out if desired (SCR provides faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Information about patients who were receiving end of life care and where "do not attempt resuscitation" (DNAR) decisions were in place, were communicated electronically to the out of hours service and London Ambulance Service or shared via the 'Co-ordinate My Care' website if the patient had opted into this service.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. We were told staff supported vulnerable patients such as those with dementia or learning disabilities to make decisions about their care. Staff we spoke with demonstrated an understanding of Gillick competencies (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Good

Are services effective?

(for example, treatment is effective)

Written consent was obtained for minor surgical procedures performed at the practice. We were shown the form used to record consent for minor surgery. There were information leaflets given to patients prior to minor surgery with information on the procedure, risks and after care to ensure consent was informed.

Health promotion and prevention

The practice had measures in place for health prevention and promotion in their patient population. Practice nurses offered health checks to all patients joining the practice. This included offering HIV finger prick tests to patients 18 years and over with same day referral to a local sexual health clinic if positive. Information about this test was displayed in the waiting area. All three practice nurses were level three trained smoking cessation counsellors. The practice had identified the smoking status of 88% of patients over the age of 15 in 2013-2014 and actively offered referral to local smoking cessation services.

Information on smoking cessation was advertised in the practice newsletter. Patients were able to self-refer to Hounslow health and well-being trainers who visited the practice every Monday and provided advice on healthier lifestyles. The practice offered opportunistic NHS Health Checks for patients aged 44-74 when they attended the practice. The electronic patient management system highlighted patients who fell into this category.

The practice offered travel vaccinations and was a yellow fever immunisation centre. They offered a flu vaccination programme in line with national guidance. The uptake of the flu vaccine in patients aged over 65 years in 2013 – 2014 was 65% which was average for the local Clinical Commissioning Group (CCG) area. For at risk patients aged over six months and under 65 years the uptake rate was 35%, which was below the local CCG average. Staff told us that older patients were invited to attend flu vaccination clinics however at risk patients below 65 years were given the vaccine opportunistically and uptake may be low because these patients were not attending the practice frequently. The practice offered a full range of childhood immunisations and the uptake rate for 2013 – 2014 was 81–96% at 12 months, 85-96% at 24 months and 77-90% at five years depending on the vaccine, which was in line with the CCG average for the local area.

Screening for breast, bowel and cervical cancer was offered in line with national standards. The practice performance for cervical smear uptake was 78% for 2013 - 2014 which was comparable with other practices in the local CCG area.

The practice offered screening for Chronic Obstructive Pulmonary Disease (COPD) in patients aged 35 years and over who were current or ex-smokers. These patients were offered a lung function test appointment and abnormal results were discussed with the patients GP. This service was advertised with an information leaflet in the waiting room.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, helpful, and courteous towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that they received compassionate care from staff at all levels. We received 33 completed Care Quality Commission (CQC) comment cards and the majority of the feedback was positive and referred to staff as kind, respectful, caring, and helpful.

Evidence from the latest GP national patient survey published by NHS England July 2014 showed that patients were satisfied with how they were treated. Eighty seven per cent said that the last GP they saw or spoke to was good at treating them with care and concern and 99% found the receptionists helpful. The practice was above average in the Clinical Commissioning Group (CCG) area for its satisfaction scores on consultations with doctors. Ninety-five per cent of respondents said that their GP was good at listening to them and 94% said their GP gave them enough time. Ninety-one per cent of respondents would recommend the practice to someone new.

We observed that conversations with the receptionists in person and on the telephone could be overheard by people sitting in the waiting area and this did not maintain patient confidentiality. However, we were told by staff there was a room available behind the reception if patients wished to discuss anything privately. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. There were information leaflets available in the waiting room on how the practice used confidential information.

Care planning and involvement in decisions about care and treatment

The results of the 2014 GP national patient survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 86% of respondents said the last GP they saw involved them in decisions about their care and 89% felt the GP was good at explaining treatment and results. Ninety-seven per cent of respondents said the last nurse they saw was good at listening to them and 91% said the nurse was good explaining tests and treatments. These results were above average compared to the local Clinical Commissioning Group (CCG) area.

Patient feedback from completed CQC comment cards reflected the survey results with many patients reporting they felt listened to and involved in their care. Patients we spoke with told us that they received appropriate explanations to make informed choices and were involved in decisions made.

We saw the practice kept a wide variety of information leaflets in the waiting room providing information on health care, health promotion and support services available to help patients make informed choices about their care. Information leaflets were also available for patients having minor surgery at the practice to support them to give informed consent to procedures.

Staff told us interpreting facilities were available for patients who did not speak English as their first language and were used to involve patients in decisions about their health care and to obtain informed consent.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and described the holistic approach taken by clinical staff. CQC comment cards we received reflected this feedback. Information in the waiting room sign-posted patients to a number of support groups and organisations for example MIND and Age UK. There were information leaflets for parents on supporting children and young adults.

The practice kept a register of patients who were carers and had a carer's policy. We observed a poster displayed in the reception area inviting patients who were carers to complete a form with reception to have this information updated on their electronic records. The practice had an identified 'carers champion' and advertised them in the waiting room as a source of support and extra information for carers.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider. There were processes in place to alert practice staff when a patient had died. Community services if involved with the patient would be informed.

Good

Are services caring?

The practice had in house access to twice weekly Improving Access to Psychological (IAPT) counselling services to which patients could be referred.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of their patients. The practice met with the local Clinical Commissioning Group (CCG) to discuss local needs and plan service improvements. One of the GP partners was the vice chairman of NHS Hounslow CCG.

There was a named GP for all patients over 75 years of age. The practice was part of one of five locality networks in Hounslow Clinical Commissioning Group (CCG) area. The group worked with the local community health and social services and a lead consultant from secondary care to identify and review patients at risk of becoming unwell. Case discussions focused on patients with diabetes and those over 75 years of age. We were told there were plans to include complex patients with lung and heart disease in these reviews in the future. The practice had a policy to see elderly patients requiring urgent care on the same day. The practice referred elderly patients at high risk of admission to the Integrated Community Response Service (ICRS). This was a multi-disciplinary team, of physiotherapists, occupational therapists and nurse assessors who reviewed patients in the community to provide urgent assessment and acute medical intervention in order to avoid hospital admission

The practice reviewed some patients in a local care home. We were told one of the GPs would visit the care home every Monday and provide health checks and prescription review for the patients under their care. Home visits were available for patients unable to attend the practice due to illness of immobility. There was a locum practice nurse shared between the three practices at the health centre that was able to perform International Normalised Ratio (INR) checks for patients taking anti-coagulants who were unable to come to the surgery for these checks.

The practice provided annual review for patients with long term conditions including diabetes, asthma and chronic obstructive pulmonary disease (COPD). One of the GPs managed a call and re-call programme for patients with diabetes for review. The practice nurses had training in managing patients with long term conditions. Patients with COPD at high risk of admission were provided with 'rescue packs' of medication to take if they became unwell at home and they were encouraged to call the practice to talk to a GP before attending accident and emergency department.

As part of Hounslow CCG the practice had access to a community oxygen assessment team for patients requiring oxygen therapy at home for long term pulmonary conditions. This team was lead by a consultant and provided review and pulmonary rehabilitation for patients with lung disease in their homes. This service was promoted in the waiting room by an information leaflet.

The practice nurses had received training in sexual health and family planning and they offered chlamydia testing opportunistically. The practice provided an ante-natal service with community midwives attending the practice on Wednesday and Thursday afternoons. There was a post-natal service with a baby clinic every Monday afternoon. The practice offered a full childhood immunisation programme in line with national guidelines. There was a policy to see children requiring urgent care on the same day. Leaflets in the waiting room promoted the Hounslow Early Intervention Service which provided support for children, young people and families. One of the practice nurses specialised in teenage health and had completed a training course in managing diabetes in teenagers. The practice had a teenager's board and bulletin in the waiting area providing information targeting patients of this age group. There was a local refuge centre for women and the practice provided medical care for women staying there as needed.

The practice offered extended appointments on Mondays and Thursdays for patients unable to attend the practice during usual working hours. Appointments and repeat prescriptions could be requested online for patients who may not be able to call or attend the practice to arrange them.

The practice kept a register of patients with learning disabilities and GPs performed annual health reviews for these patients with additional appointment time allocated. The practice kept a record of patients who were carers and information in the waiting room encouraged carers to provide this information to be recorded on their electronic records for the GP to be aware of.

The practice offered annual review for patients with poor mental health. There was a register of patients with a diagnosis of dementia and those patients currently under investigation for dementia. The practice had in house weekly access to refer patients to Hounslow iHEAR drug and alcohol reach team, which is an integrated service to

Good

Are services responsive to people's needs?

(for example, to feedback?)

support those affected by drug and alcohol dependence. The practice had in house access to twice weekly Improving Access to Psychological (IAPT) counselling services to which patients could be referred.

The practice kept a register of patients receiving end of life care and this was shared with the out of hour's provider. GPs told us they had a close working relationship with community palliative care to support these patients at home. GPs were encouraged to complete 'Co-ordinate my care' records for palliative care patients to document their wishes within care plans.

Tackling inequity and promoting equality

The practice had access to an interpreting service for patients who did not have English as their first language.

The premises were accessible to patients with disabilities, for example there was street level access to the practice and consultation rooms on the ground floor. The waiting room was large enough to accommodate wheelchairs and prams. We observed one of the accessible toilets which had baby change facilities inside was out of order. We were told this had been closed for some time and it had been reported to the building manager but it had not been chased up. In the interim a room by reception had been used for baby changing.

Access to the service

The practice was open from 7.00am to 6.30pm with further extended hours on Monday to 7.30pm. There was a recorded answer phone message providing out-of-hour contact information for when the reception was closed. Appointments were bookable in person, on telephone and online. Surgery times varied depending on GP as each individual GP had their own surgery times giving patients the choice to book appointments with their preferred GP. Information on appointment times was available in the practice leaflet and website. There was a minor surgery clinic on a Friday.

Urgent appointments were available with the duty doctor by telephoning or attending the practice on the day. Non urgent appointments were available within two working days but could also be booked up to four weeks in advance. Home visits were available for patients unable to attend the practice due to illness or immobility. Information on out of hours services was provided in the practice leaflet, website and in the practice newsletter.

Feedback from the national GP survey published in 2014 was positive about the appointment system. Ninety-three per cent of respondents described their experience of making an appointment as good and 92% were satisfied with the surgery's opening hours. Feedback from completed Care Quality Commission (CQC) comment cards was also positive about the appointment system however 2 out of 33 mentioned occasional long waits from appointment time. This was reflected in the national GP survey results with 50% of respondents saying they would usually wait fifteen minutes or less after their appointment to be seen.

The practice was situated on the ground floor of the health centre and had level access for wheel chair users. There were accessible toilet facilities available.

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. Information on the complaints procedure was available in the practice leaflet and on the practice website.

Patients were advised to make formal complaints to the practice manager who would acknowledge the complaint within two working days. The complaint would then be investigated and responded to within ten working days. The complaints leaflet also provided information on escalation processes to the Hounslow Patient Advisory Liaison Service (PALS) or the Health Service Commissioner if patients were not satisfied with the response.

Staff told us complaints were discussed and reviewed annually to identify learning points but we were not shown minutes of these meetings. We reviewed three complaints made for the years 2013/2014 and saw that learning points had been identified for each one.

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 an ethos to treat all patients promptly, courteously and in complete confidence and this was displayed on the practice website and in the practice leaflet. The staff set yearly objectives for the practice for development and improvement. We saw the objectives for 2014 included topics such as domestic violence training for practice staff and service expansion at the health centre. Each objective included the method to achieve the goal, the lead member of staff for the objective and the expected date of completion.

Governance arrangements

The practice had policies and procedures in place to govern activity. The practice manager met weekly with the GP's to discuss issues and performance at the practice. There were no minutes available for these meetings but the practice manager showed us the agenda for these meetings. They did not routinely record outcomes or action plans as a result of these meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw QOF data that showed the practice had met the minimum standards in atrial fibrillation, high blood pressure, learning disabilities and osteoporosis and the majority of the standards in diabetes, asthma and kidney disease.

The practice undertook a number of clinical audits to monitor performance and improve outcomes. For example, the practice had performed a recent audit on cervical smears and had made changes to the service to reduce the rates of inadequate specimen taking.

The practice had a system in place for reporting, recording and monitoring significant events. A significant record was completed by the staff members involved for any significant event that occurred and these were discussed to identify learning points to inform future practice.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles, for example GP leads in child health and minor surgery. Staff told us they felt supported by the GP's and management team and were comfortable to approach them with any issues they had. There was an open door policy to discuss any concerns with the management team.

The practice manager was responsible for human resources policies and procedures. We reviewed a number of policies, for example recruitment policy, induction policy and whistle blowing policy, which were in place to support staff. These policies were available in the employee handbook given to new starters at the practice.

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

The practice gathered feedback from a variety of sources including national patient surveys, patient feedback questionnaires and complaints. The practice complaint leaflet included a tear out comment card that patients could submit to reception staff to give feedback and make suggestions for improvement. We were told the practice was planning to implement the national 'Friend and Family test' in December 2014 that asked patients if they would recommend a service to their family and friends.

The practice had a patient participation group (PPG) that met four times a year. As a result of feedback from patients unable to attend the PPG meetings the practice organised a 'virtual PPG' for patients to participate in discussions via email. The PPG had 11 members including members of the practice staff with an average age between 55 – 74 years. The virtual PPG had 109 members with an age range of 16 – 74 years. The PPG report from 2013/2014 identified patient groups that were under-represented and aimed to recruit members from these groups by advertising through the practice website, practice newsletter and directly by reception staff.

The practice made changes to the service as a result of patient feedback. For example, many patients had responded 'don't know' to questions about services the practice provided in the 2012/2013 patient survey. As a result the practice had developed an information leaflet titled 'What you think you know but actually you don't know' to advertise their services. This included details about service provision, online appointment bookings and extended opening hours. As a result of the 2013/2014 patient survey the practice aimed to provide a service to update patients on surgery wait times but this had not been implemented.

Feedback from staff was gained informally with daily meetings between the practice manager and the reception team. We were told the practice motivated staff through

Are services well-led?

Good

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

provision of training opportunities, encouraging responsibility and through financial incentives to best performing staff. They did not conduct a staff survey to gain feedback.

The practice had a whistle blowing policy which was available for staff to access in the employee handbook. Staff we spoke with were aware of the policy and the process to follow if they had any concerns.

Management lead through learning and improvement

The GP's received annual appraisal as part of their required professional development. There were no annual appraisals for the administration staff, however the practice manager spoke with them on a daily basis to discuss any issues and these discussions were documented. We saw evidence that these meetings had taken place. The practice manager told us this was more beneficial than annual appraisal.

Staff told us they felt supported in their training needs by the practice. Staff were encouraged to identify areas for training and approached the GPs to arrange this. The practice attended Hounslow Education and Training (HEAT) meetings which were protected learning seminars for all staff. They included talks from external specialists, for example Consultant in Child and Adolescent Mental Health and palliative care.