

# Blue Wing Family Doctor Unit

## Quality Report

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

### Ratings

#### Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Requires improvement



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 a comprehensive inspection of Blue Wing Family Doctor Unit on 11 November 2014. We rated the practice as 'Requires Improvement' for the service being safe and caring, and 'Good' for the service being effective, responsive to people's needs and well-led. We rated the practice as 'requires improvement' for the care provided to older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

We gave the practice an overall rating of 'requires improvement.'

Our key findings were as follows:

- Safety systems were in place including medicine management, safeguarding procedures, infection control standards and risk assessments.

- Staff had a good skills mix and had received adequate training and development to deliver effective care to patients.
- The practice understood the needs of the population and provided services to meet their needs.
- Appointments were available by telephone or online and the service was accessible at weekends for those patients who could not attend during the week.
- Translation services were available for patients whose first language was not English and the practice was accessible to those with disabilities.
- The practice sought feedback from patients and used it to improve services.

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

Importantly, the provider must:

- Carry out criminal record checks on all staff who act as chaperones.

In addition the provider should:

# Summary of findings

- Ensure patients are treated with care and concern and involved in decisions about their care by all staff members.
- Complete clinical audit cycles to ensure that identified improvements are achieved and maintained

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. However we found that criminal record checks had not been carried out on non-clinical staff who acted as chaperones.

Requires improvement



### Are services effective?

The practice is rated as good for providing effective services. NICE guidance was referenced and used routinely by the GPs. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' mental capacity and the promotion of good health. Multidisciplinary working was evidenced. Staff had received training appropriate to their roles to deliver effective care to patients. The practice had completed appraisals and personal development plans for all staff.

Good



### Are services caring?

The practice is rated as requires improvement for providing caring services. This was because national patient survey data showed patients rated the practice lower than others for some aspects of care. The majority of patients said they were treated with compassion, dignity and respect. However not all felt cared for, supported and listened to by staff. Some patients felt they were not always involved in decisions about their care and their privacy was not always respected.

Requires improvement



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported they could usually get appointments to suit them with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with all staff.

Good



# Summary of findings

## Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision and strategy and staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve the quality of the service and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

Good



# 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 is rated as requires improvement for the care of older people.

The practice had identified older patients who were at risk of unplanned admission to hospital and had developed care plans for these patients to reduce the likelihood of hospital admission. All patients over 75 years old had a named GP. The practice attended multidisciplinary team meetings to plan care for patients with end of life care needs. The practice had scored above the CCG and national averages for palliative care in QOF year 2013/14. The practice provided care for 10 older patients in residential care homes and had developed care plans for these patients to meet their health needs.

The provider was rated as requires improvement for safe and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**



### People with long term conditions

The practice is rated as requires improvement for the care of people with long-term conditions.

The practice had recall systems and protocols in place for the care of patients with long-term conditions including input from the health care assistant, practice nurse and GPs. The practice monitored patients with long-term conditions using their quality and outcomes framework (QOF) performance. The practice had achieved 76% in its performance against the various disease registers within the QOF framework in the previous year which was below CCG and national averages. However we found that the practice had improved its performance in the current year.

The provider was rated as requires improvement for safe and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**



### Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people.

The practice provided family planning clinics including contraceptive services. The practice attended multidisciplinary team meetings to review the needs of children on the 'at risk' register. The practice had an alert system in place to highlight children on child

**Requires improvement**



# Summary of findings

protection plans and staff were trained to recognise the signs of abuse in children. Staff knew the reporting procedures if they had any concerns and were trained to the required level in child protection.

Appointments were available outside of school hours and the premises were suitable for children and babies.

Latest figures showed the number of eligible children receiving immunisations averaged 90% over the previous six months which was above the CCG average.

The provider was rated as requires improvement for safe and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

## **Working age people (including those recently retired and students)**

The practice is rated as requires improvement for the care of working age people (including those recently retired and children).

The practice provided accessible appointments at times convenient for people who were working or in full-time education. For example appointments were available at weekends. In addition the practice offered telephone consultations and online appointment booking.

The provider was rated as requires improvement for safe and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**



## **People whose circumstances may make them vulnerable**

The practice is rated as requires improvement for people whose circumstances may make them vulnerable.

The practice kept a register of all patients with learning disabilities and all patients with learning disabilities had received annual physical health checks. The practice had an open access policy for homeless people. The practice also had a carers register to identify carers who might be in need of extra support. The practice had access to online and telephone translation services and staff spoke a number of languages including Hindi, Urdu, Portuguese and Nepali to help patients whose first language was not English to access services.

The provider was rated as requires improvement for safe and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**



# Summary of findings

## People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for people experiencing poor mental health (including people with dementia).

The practice kept a register of patients experiencing poor mental health and had developed care plans for the majority of these patients. The practice had scored above the CCG and national averages for dementia care in their QOF performance in the previous year.

The practice participated in transfer of care for patients with serious and enduring mental health issues. (In this scheme the responsibility of care is transferred from secondary to primary care services).

The provider was rated as requires improvement for safe and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**





# Summary of findings

## What people who use the service say

We spoke with eight patients during the course of our inspection including the chair of the Patient Participation Group (PPG). We reviewed 23 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service. We also reviewed the results of

the practice's most recent patient experience survey and the 2014 national GP patient survey. Patients were generally satisfied with the service however some patients said they were not always treated with care and concern and are involved in decisions about their care by all staff members.

## Areas for improvement

### Action the service **MUST** take to improve

Carry out criminal record checks on all non-clinical staff who act as chaperones.

### Action the service **SHOULD** take to improve

Ensure patients are treated with care and concern and are involved in decisions about their care by all staff members.

Clinical audit cycles should be completed to ensure that identified improvements are achieved and maintained.

# Blue Wing Family Doctor Unit

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

## Background to Blue Wing Family Doctor Unit

Blue Wing Family Doctor Unit is situated at 92 Bath Road, Hounslow, TW3 3EL. The practice is based in purpose built premises which it shares with other practices. The practice provides primary care services through a GMS contract to 7820 patients in the local area. The practice is part of the NHS Hounslow Clinical Commissioning Group (CCG) which is made up of 54 GP practices that serve a population of 288,000. The practice serves a young population group with patients predominantly in the 18-65 years age range from diverse ethnic backgrounds. The practice staff comprises of three male GP partners, one female GP partner, a practice nurse, a healthcare assistant, a practice manager and a small team of reception/administration staff. The practice opening hours are 8.30am to 6.30pm Monday to Friday with the exception of Wednesdays where the practice closes at 1.30pm. The practice offers extended hours on Saturdays from 8.00am to 12.00pm. The practice has opted out of providing out-of-hours services to its patients and refers patients to the 111 out-of-hours service.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice offers a range of clinics and services including chronic disease management, family planning, cervical screening, child health surveillance, joint injections and IUCD fitting, travel advice and vaccinations and health promotion.

## Why we carried out this inspection

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. This provider had not been inspected before and that was why we included them.

## How we carried out this inspection

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

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

# Detailed findings

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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 November 2014. During our visit we spoke with a range of staff including three GPs, the nurse, the practice manager and three reception/administration staff and spoke with eight patients who used the service including the two members of the Patient Participation Group (PPG). We reviewed 23 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 track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example a recent incident involved the surgery telephone system failing. The incident had been reported in line with practice policy and investigated promptly.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could evidence a safe track record over the longer term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. Significant events were discussed at monthly practice meetings where they were a permanent agenda item. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example an incident we reviewed involved the surgery telephone system failing which meant patients could not phone the practice. This was discussed in a staff meeting where it was decided that an emergency number should be made available if the incident happened again in the future. Staff including receptionists, administrators, and nursing staff were aware of the system for raising issues to be considered at the meetings and said they were encouraged to do so. All staff had received training in managing significant events.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. For example, a safety alert was received regarding a vaccine batch number error. The vaccine was removed from stock and replaced. Staff also told us alerts were discussed in practice meetings to ensure staff were aware of any relevant to the practice and where action needed to be taken.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. The GPs, nurse and health care assistant had received child protection training to Level 3 and reception/administration staff to Level 2. All staff had received training on safeguarding vulnerable adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were displayed throughout the practice as a quick reference for staff.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children. All staff we spoke to were aware of who this lead was and who to speak to in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

A chaperone policy was in place and information on chaperoning was displayed in the waiting area. Chaperone training had been undertaken by the nurse and the health care assistant. If clinical staff were not available to act as a chaperone the receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. However we found that criminal record checks via the Disclosure and Barring Service (DBS) had not been carried out on non-clinical staff who acted as chaperones.

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

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

## Are services safe?

clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with relevant regulations. Vaccines were administered by the nurse using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, the training requirements of staff generating repeat prescriptions and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the disposal of controlled drugs.

### Cleanliness and infection control

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the lead had carried out annual infection control audits and that any improvements identified for action were completed on time. For example the most recent audit had identified an area of carpet in the practice was torn increasing cross infection risks. As a result of the audit the carpet had been repaired.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury and the policy was displayed as a quick reference for staff.

Signs reminding staff of effective hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice manager told us a risk assessment for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings) had been carried out. However we did not see evidence of this as the property management company was responsible for implementing the recommendations from the risk assessment and the practice did not have access to it.

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was in place. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example fridges for vaccine storage, the fridge thermometer, spirometers, blood pressure monitors and weighing scales.

### Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, and registration with the appropriate professional body. Criminal records checks via the Disclosure and Barring Service had been obtained for clinical staff however non-clinical staff had not received a criminal check despite acting as chaperones. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to

## Are services safe?

meet patients' needs. We saw there was a rota system in place covering different staff groups to ensure they were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave and sickness.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

The practice had Service Level Agreements in place with locum agencies and a comprehensive locum pack was in place.

### Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building and the environment. The practice had a health and safety policy and an identified health and safety representative who staff were aware of if they needed to report any concerns. Staff had also received training on health and safety in the practice.

Health and safety risk assessments were in place including risk assessments for fire and infection control. Where risks had been identified control measures were in place to minimise them.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support on an annual basis. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed this was checked daily.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included emergency medicines for the treatment of anaphylaxis, myocardial infarction, angina and asthma. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the relevant electricity, gas or water companies to contact in the event of supply failures.

A fire risk assessment had been undertaken and staff were up to date with fire training. Regular fire drills were undertaken to ensure staff could evacuate patients safely in the event of a fire.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. New guidelines were accessible via the practice's computer system and were discussed and shared at monthly clinical meetings. We found from our discussions with the GPs that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

All the GPs shared the lead for the management of long-term conditions which had a high prevalence in the patient population such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. The practice nurse supported this work which allowed the practice to focus on patients with these specific conditions. Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance.

The practice referred patients to secondary care and other community care services in line with national guidance. This included urgent two week wait referrals for suspected cancer. The practices' referral rates to secondary care were in line with CCG averages and referrals were discussed and compared with other local practices at monthly network meetings.

We found that accident and emergency admissions to hospital were higher than the CCG average. The practice was aware of this and was looking at ways of reducing the number of admissions. For example the practice was providing a new enhanced service (services which require an enhanced level of service provision above what is normally required under the core GP contract) to reduce unnecessary admissions to secondary care. The aim of the enhanced service was to proactively manage 2% of 'at risk' patients over 18 years of age by developing care plans for them. At the time of our inspection the practice was above target and had developed care plans for 3% of the patients identified.

The practice provided effective care to patients with complex needs. Patients identified as having complex needs by the computerised risk tools were invited in for a consultation. The GPs developed care plans for these

patients when they attended the practice. Care for patients with complex needs was discussed at monthly multidisciplinary team meetings and the meeting minutes we reviewed confirmed this.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

### Management, monitoring and improving outcomes for people

The practice was monitoring and improving outcomes for patients through their Quality and Outcomes Framework (QOF) performance. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. The practice had achieved 83.4% of the QOF points available and 76.4% of the points available for the clinical domains in 2013/14. These results were below the CCG and national averages. We saw evidence from meeting minutes that the practice had analysed their QOF performance and had taken action to improve services. For example the practice had improved its performance in asthma, COPD, diabetes and hypertension.

The practice provided us with audits they had undertaken. These included audits of cervical screening to identify inadequate smears, referrals to secondary care to monitor patients who did not attend their appointments, delayed prescriptions and patient record audits. Some actions for improvement had been identified as a result of the audits. However, we found that audit cycles were incomplete, in that the audit had not been repeated to assess if performance had improved.

The practice participated in benchmarking and peer review with other practices in the CCG through locality and network meetings. Topics discussed included referrals to secondary care, accident and emergency attendances, prescribing and unplanned admissions to hospital.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as fire safety, health and safety, basic life support and anaphylaxis, infection control and



# Are services effective?

## (for example, treatment is effective)

safeguarding. Staff had also received training in topics relevant to their job role. For example the practice nurse had received training in immunisations and clinical staff who were registered smear-takers had received cervical smear training. The GPs and nurse had skills relevant to the needs of the practice population. For example two GPs had a special interest in diabetes and the nurse had been trained to initiate insulin. The GPs were registered with the General Medical Council (GMC) and the nurse registered with the Nursing and Midwifery Council (NMC).

All GPs were up-to-date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). All staff including locums had completed an induction programme when they started working for the practice.

All staff received an annual appraisal and developed a personal development plan with timelines for completion. Staff told us they were actively encouraged to develop and contribute to their personal development plans and said they were supported to deliver effective care.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post.

The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. Staff told us that there were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example, those with end of life care needs, mental health needs or children on the at risk register. These meetings were attended by social workers, the palliative care team,

hospital consultants, psychiatrists and diabetic specialists and were used to review and plan the care for these patients. GPs also attended child protection/vulnerable adults meetings to discuss at risk patients.

### Information sharing

Patients were referred to other services/specialists through on the day referrals by the GP's. We found the practice referral process was efficient and in line with national guidelines. Patients we spoke with had no issues with the referral process and they said that the GP's always referred them promptly.

The practice had systems in place to provide staff with the information they needed. An electronic patient record (SystemOne) was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice utilised a clinical service called 'coordinate my care.' The service allowed the sharing of information on patients between health care providers. The practice used this service to manage patients requiring end of life care. Information was shared between the GP, social services and palliative care team to provide effective care for these patients.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties under this legislation. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice, for example, when making best interest decisions for patients who lacked capacity.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us all 38 patients on the learning disabilities register had a care plan in place.

GPs demonstrated an understanding of Gillick guidelines (legislation used to decide whether a child or young person



# Are services effective?

(for example, treatment is effective)

16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge) and were able to give examples of when they had used them.

Written consent was sought for minor surgery for example when a GP administered joint injections.

## Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice proactively offered NHS Health Checks to all its patients aged 40-75. Practice data showed that by April 2014, 350 health checks had been completed out of 378 patients identified for one.

The practice had a number of ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. The practice had 38 patients with learning disabilities and they had been offered annual physical health checks. The practice had also identified the smoking status of its patient population over the age of 16 and actively offered smoking cessation advice to these patients. Latest figures

showed that smoking cessation advice had been given by the nurse or health care assistant to 965 patients out of 1020 identified for advice. At the time of our inspection the practice was not monitoring the number of patients who had managed to stop smoking as a result of the advice given.

The practice offered cervical screening with an uptake of 76% of eligible patients. The practice was not offering HIV, chlamydia or cancer screening. Patients were referred to hospital for these services.

The practice offered a full range of immunisations for children, travel vaccines and shingles vaccinations in line with current national guidance. Latest figures showed the number of eligible children receiving immunisations averaged 90% over the previous six months and the practice had performed above the CCG average. However we found that the percentage of over 65 year old patients receiving the seasonal flu vaccination was below the national average. The practice told us this was due to challenging demographics.

The practice offered a wide range of information on health issues so patients could make informed decisions about their health. This included information on family health, long-term conditions and minor illness. Patients were signposted to support services including the alcohol dependency service and therapeutic services for families and children.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national GP patient survey and a patient experience survey conducted by the practice. The evidence from these sources showed patients were not always satisfied with the practice. For example the results of the 2014 national GP patient survey showed that 76% of respondents described their overall experience of the surgery as good and 67% would recommend the practice to someone new in the area. Both these results were below CCG averages. Patients were also not always satisfied with how they were treated by staff at the practice. For example the results of the 2014 national GP survey 2014 showed that only 56% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern and 60% said the nurse was good at giving them enough time. These results were below the CCG averages of 71% and 74% respectively and this was also reflected in comments we received from patients during our inspection.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 23 completed cards which were mainly positive about the service experienced. Patients said they felt the practice offered a good service and staff were caring. They said staff treated them with dignity and respect. Patients were not always satisfied with the level of privacy at the reception and this was reflected in the 2014 national GP survey which showed the practice scored below the CCG average with only 59% of respondents being satisfied with the level of privacy when speaking to receptionists at the practice. However we noted that a sign was displayed at reception informing patients that a room was available if they wanted to speak with staff in private. Patients were satisfied with the level of privacy during consultations and treatments. We saw that disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was

maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

### **Care planning and involvement in decisions about care and treatment**

The 2014 national GP survey information we reviewed showed a mixed response from patients in relation to questions about their involvement in planning and making decisions about their care and treatment. We found that 71% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care which was above the CCG average. However only 55% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care which was below the CCG average. These results were also reflected in comments received from patients during our inspection.

Staff told us that translation services were available for patients who did not have English as a first language to ensure they could understand treatment options available and give informed consent to care. We saw notices in the reception areas informing patients this service was available.

### **Patient/carer support to cope emotionally with care and treatment**

Patients we spoke with said they were satisfied with the emotional support provided by staff at the practice and this was reflected in the CQC comment cards we received.

Notices in the patient waiting room and on the practice website also signposted people to a number of support groups and organisations including bereavement support and counselling. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We saw from meeting minutes that the practice engaged with the CCG on a monthly basis to discuss local population needs and service improvements. This included weekend access to the practice and avoiding unplanned admissions to secondary care. For example to meet the needs of the working age population the practice had collaborated with other practices in the CCG to offer weekend appointments on a rota basis. The practice offered an enhanced service for patients over 18 years of age at risk of unplanned admission to hospital. The practice had identified appropriate patients through risk stratification and had developed care plans for 3% of those identified to meet their care needs. Due to demand the practice had introduced a phlebotomy service to provide blood tests for patients and a clinic to carry out INR tests for patients prescribed warfarin. The practice provided focused diabetic care and the GPs and nurse were trained to initiate insulin to meet the needs of patients with diabetes for whom this was appropriate.

The practice used computerised risk tools to identify patients with complex needs. Patients identified were invited into the practice for a review and to plan care that met their needs. The computer risk tools helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The purpose of the PPG was to represent patients' views and met every two months. For example the PPG found that patients were not aware of the practice's register of carers. As a result the practice had raised awareness by providing leaflets and updating the practice website.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the practice had an open access policy for homeless people. The practice also provided longer appointments for patients with learning disabilities and maintained a register of carers to

identify carers who may be in need of extra support. The practice provided care for 10 older patients in residential care homes. The practice had developed care plans for these patients to meet their health needs.

The practice had access to online and telephone translation services and staff who spoke a number of languages including Hindi, Urdu, Portuguese and Nepali. The computer check-in system at reception was available in four different languages common to the local area. The practice website could also be translated into 84 different languages.

The premises and services had been adapted to meet the needs of people with disabilities including a lift for wheelchair and mobility scooter users and modified toilet facilities. The practice provided equality and diversity training and staff we spoke with confirmed that they had completed this training.

### Access to the service

The practice opening hours were 8.30am to 6.30pm Monday to Friday with the exception of Wednesdays where the practice closed at 1.30pm. The practice offered extended hours on Saturdays from 8.00am to 12.00pm which was particularly useful to patients with work commitments and had been implemented due to patient feedback. The practice also opened every six weeks on Saturdays 10.00am to 4.00pm and Sundays 12.00pm to 4.00pm to further improve access. Appointments were bookable up to six weeks in advance by telephone or online. Emergency appointment slots were available on the same day. Appointments were usually 10 minutes in length, however, 20 minute slots were available if required. The practice offered telephone consultations for minor conditions and home visits were carried out for those patients who were housebound. Patients could also register on the practice website to receive text message reminders regarding their appointments. Repeat prescriptions could be requested by filling in a form at reception or online via the practice website and they were available within 48 hours for collection. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by a primary care out of hours service.

We reviewed the results of the 2014 national GP survey and found that 59% of respondents had to wait 15 minutes or less after their appointment time to be seen and 81% said the last time GP they saw or spoke to was good at giving

# Are services responsive to people's needs?

## (for example, to feedback?)

them enough time. These results were in line with CCG averages. However only 53% of respondents found it easy to get through to the practice by telephone which was a long way below the CCG average of 70%. Patients we spoke with during our inspection also raised concerns about getting through to the practice by telephone and this was reflected in the practice's most recent patient survey. The practice was aware of this feedback and had employed more reception staff to improve telephone access for patients. However the main issue was with the telephone system itself. The practice manager told us that the phone system was part of the hardware in the building and although they had requested it to be changed, it was not something the property company would allow. Despite issues with the telephone system patients we spoke with said they could usually get an appointment that suited them and this was reflected in the comment cards we received.

The practice was situated on the first floor of the building which it shared with other practices. The practice was accessible to patients with wheelchairs, mobility scooters and prams via a lift. The waiting area was large enough to accommodate them and there was easy access to the consultation rooms and toilet facilities.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures

were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system including information on the practice website and a leaflet available at reception. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at five complaints received over the previous year and found these were satisfactorily handled and dealt with in a timely way in line with the practice's complaints policy.

The practice regularly discussed complaints in practice meetings and complaints were reviewed on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. Both clinical and non-clinical staff had received training about the practice's complaints procedure.

# 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's mission statement was to provide the highest standard of professional care to its patients. To achieve this aim the practice was focused on improving access for all patients and improving clinical care in disease areas with a high prevalence such as diabetes and asthma. Staff we spoke with were aware of the mission statement and their responsibilities in relation to it. The mission statement was included in the practice information leaflet for patients to view.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a number of these policies and found they had been reviewed annually and were up to date. Policies we reviewed included safeguarding children and adults, infection control, medicine management, prescribing and consent.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice had scored below the CCG and national averages in their 2013/14 QOF performance. However we found the practice had improved its performance in the current year. The practice had a lead GP responsible for QOF and we found that QOF performance was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice was participating in benchmarking and audit. However, the practice was unable to show us evidence of a systematic approach to improving outcomes for patients through clinical audit. Audit cycles were incomplete, in that audits had not been repeated to assess if performance had improved.

### Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example the practice nurse was the lead for infection control and medicine management. A GP was the lead for safeguarding, information governance and QOF and a second GP was the lead for commissioning. A third GP was the lead for the Patient Participation Group (PPG) and the practice manager responsible for complaints handling. We

spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

A range of meetings were held on a regular basis. These included monthly clinical meetings for the GPs and nurse, non-clinical meetings for administration staff and governance meetings for the GP partners. Topics discussed in clinical meetings included prescribing, catheter management, accident and emergency attendances, referrals to secondary care and QOF performance. We also saw meeting minutes from the non-clinical meetings where day to day issues were discussed including complaints and administrative topics. The GPs attended monthly network and locality meetings with other practices from the CCG where the practice participated in benchmarking and peer review. The GPs also attended multidisciplinary team meetings every two months where complex cases were discussed. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings. Staff said they were listened to felt supported in their role.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, induction, appraisal, maternity and whistleblowing policies as well as the disciplinary policy and sickness procedures which were in place to support staff. Staff we spoke with knew how to access these policies and the policies had been reviewed on an annual basis. There was also a staff handbook to support staff with all areas of their job role.

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

The practice had a patient participation group (PPG) which comprised of 10 members. The group had a varied membership by age, sex and ethnicity. The practice was actively recruiting more patients for the PPG and had advertised for new members at the practice reception. The PPG had carried out annual patient surveys and met every two months to discuss feedback. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from the survey were available on the practice website.

The practice had gathered feedback from patients through patient satisfaction questionnaires carried out by the PPG,

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Good 

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a suggestion box at reception, complaints received and feedback on the practice website. Feedback received through the suggestion box was reviewed by the practice and a newsletter compiled and circulated. We reviewed a recent newsletter and found patients' concerns had been responded to by the practice team. For example a patient had complained that a vaccine was not available when they attended the practice for a vaccination. As a result the practice had put a system in place to ensure the relevant vaccines are in stock before patients attended their appointments. Another patient had complained about the difficulty of getting through to the practice on the telephone and as a result the practice had increased the number of reception staff on duty to answer the telephones. The practice had also developed action plans as a result of patient satisfaction questionnaires and made improvements to the service. For example results of the latest patient survey showed that 70% of patients did not know about the carers register. We found the practice had raised awareness of the carers register as a result of this feedback. The survey also showed that 31% of respondents

were not aware of the practices' 24 hour online appointment booking facility. As a result the practice had updated the practices' information leaflets to promote the online services more clearly and staff had been trained to explain to patients the different types of appointment available.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff records and saw that annual appraisals took place which included a personal development plan detailing staff training needs and timelines for completion. Both clinical and non-clinical staff told us that the practice was supportive of training.

The practice had completed reviews of significant events and other incidents and shared lessons learnt with staff via meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers  <b>How the regulation was not being met:</b>  People who use services and others were not protected against the risks associated with unsafe or unsuitable care because the provider had not carried out criminal checks on all staff acting as chaperones. Regulation 21.