

# Dr D Varma

## Quality Report

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Date of inspection visit: 20 October 2016

Date of publication: 13/12/2016

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 Dr D Varma on 20 October 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, 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.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- The practice should take steps to ensure that safety checks of electrical equipment are carried out regularly.
- The practice should consider reviewing its complaints process to ensure that all complaints are being recorded, including those made verbally, so that trends and patterns can be identified and learning points can be used to bring about improvements.
- The practice should continue to pro-actively identify and support patients who are also carers.

**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 good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Good



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Good



### Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice as higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



# Summary of findings

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Over fifty percent of the practice population did not have English as a first language and information was frequently available in Bengali which was the locally prevalent community language.
- The local area had historically achieved low uptake rates for health screening programmes and the practice had responded to this by collaborating with three other local GP practices to produce a set of broadcast quality videos to explain the advantages of participating in health screening. These videos were available in Bengali and were prominently positioned on the practice website.
- The practice had used local community networks (including a local Mosque attended by many of the practice population) to deliver health promotion messages.
- The practice had in-house fluency skills in Bengali, Hindi, Gujarati, Urdu, French and Italian.
- 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. However, verbal complaints were not always recorded which meant that trends or patterns might not always be identifiable.

## Are services well-led?

The practice is rated as good for being well-led.

Good



- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

# Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

# 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 good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Outcomes for conditions often associated with older people were comparable to or above local and national averages. For instance, 98% of patients with hypertension had well controlled blood pressure compared to the CCG average of 88% and the national average of 84%.
- Home visits for NHS health checks for older people could be arranged with the practice health care assistant and this had been risk assessed for the safety of the staff member as well as for the patient.

Good



### People with long term conditions

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

- GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The health care assistant had been trained to provide day to day support for patients with long term conditions.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



### Families, children and young people

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

Good



# Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 85%, which was comparable to the CCG average of 79% and the national average of 82%.
- Outcomes for patients with asthma were above CCG and national averages. For instance, 94% had had an asthma review in the preceding 12 months using a nationally recognised assessment tool.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with local GP practices and health visitors and engagement with local community networks.

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

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Two members of staff had trained as phlebotomists so that working patients who found it difficult to attend specialist phlebotomy clinics for blood tests, could arrange to have them done at the surgery during the extended surgery hours.

**Good**



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

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.

**Good**



# Summary of findings

- The practice offered longer appointments for patients with a learning disability.
- All staff had been trained in learning disability awareness and used this training to provide suitable support to patients who needed it, for instance, by allowing greater flexibility around appointments.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice had collaborated with three local GP practices to produce a series of information and health promotion videos and these were available in Bengali which was the most common language spoken amongst the practice population.

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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- All patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is above the national average of 84%.
- 92 % of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good





# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Three hundred and fifty nine survey forms were distributed and 60 were returned. This represented 2% of the practice's patient list.

- 81% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 75% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 77% of patients described the overall experience of this GP practice as good compared to the national average of 85%.

- 70% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 43 comment cards which were all positive about the standard of care received. People said staff were friendly and helpful and that doctors were attentive and caring.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. All five told us that GPs encouraged them to lead healthier lives and gave us examples of how they had been supported to do so, for instance through the recommendation of suitable fitness exercises and healthy eating advice.

# Dr D Varma

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.  
The team included a GP specialist adviser.

### Background to Dr D Varma

Dr D Varma, also known as Brayford Square Surgery is one of the member GP practices in the Tower Hamlets Clinical Commissioning Group (CCG). The practice is also a member of the Stepney and Whitechapel Network, a CCG sub-group of four GP surgeries in the local area.

The practice provides GP primary care services to approximately 3,400 people living in Stepney, London Borough of Tower Hamlets. Services are provided under a General Medical Services (GMS) contract with NHS England. A General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice is located in a single storey building and all rooms are fully accessible.

Information published by Public Health England indicates the practice is located in one of the most deprived parts of England. For example, Income Deprivation Affecting Older People (IDAOPI) is 59% (compared to the CCG average of 49% and the national average of 16%). Income Deprivation Affecting Children (IDACI) is 39% (CCG average 39%, national average 20%). At 76 years, male life expectancy is lower than the England average of 79 years; and at 82 years, female life expectancy is lower than the England average of 83 years. The practice population is predominantly of Asian ethnicity, with patients of Bengali ethnic origin being the largest ethnic group at 70%.

One of the partners had recently left the practice and the provider was in the process of amending its registration status from partnership to sole provider. The practice is registered to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or injury, maternity and midwifery services and family planning.

There are currently two GPs, one female and one male, both of whom are part-time and provide a combined total of 16 GP sessions per week. The clinical team is completed by a locum nurse who works part time and one health care assistant. There is also a practice manager and two reception staff. The health care assistant and practice manager are trained as phlebotomists. (Phlebotomists are specialist healthcare assistants who take blood samples from patients for testing in laboratories).

The practice opening hours are:

Monday 8:00am to 8:00pm

Tuesday 8:00am to 6:00pm

Wednesday 8:00am to 6:00pm

Thursday 8:00am to 1:00pm

Friday 8:00am to 6:00pm

Saturday Closed

Sunday Closed

Telephones are answered between 8:00am and 6:30pm daily except Thursdays when the surgery closes at 1:00pm. Patients are directed to Tower Hamlets CCG Out Of Hours GP service (OOH) outside these times, including Thursday afternoons. The details of the how to access the OOH service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website.

# Detailed findings

Patients can book appointments in person, on-line or by telephone. Patients can access a range of appointments with the GPs and nurses. Face to face appointments are available on the day and are also bookable up to four weeks in advance. Telephone consultations are offered where advice and prescriptions, if appropriate, can be issued and a telephone triage system is in operation where a patient's condition is assessed and clinical advice given. Home visits are offered to patients whose condition means they cannot visit the practice.

The practice had not previously been inspected.

## 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. The 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out a comprehensive inspection on 20 October 2016. During our visit we:

- Spoke with a range of staff including GPs, the practice manager, members of the reception and administration

team and spoke with patients who used the service. We also spoke with a representative of the Stepney and Whitechapel Network, of which Brayford Square Surgery was a member.

- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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)

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

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The practice had recorded eight significant events in the previous twelve months. We saw evidence that lessons were shared and action was taken to improve safety in the practice.

For example, we saw a record of an incident when a patient had requested a prescription when test results received from a local hospital indicated the presence of a particular condition. When the prescription was requested at the practice, the GP was concerned that the test results did not seem to concur with the GP's knowledge of the patient. The GP had discussed the request with a community health worker who also worked with the patient and they had agreed that the test results did not correspond with what they knew about the patient. The GP contacted the hospital and was told that there was an error with the results and that those of a different patient had been sent in error. Although the prescription was not issued and the mistake had been explained to the patient and the hospital, the practice had recorded the incident as a near miss and

reviewed the practice prescribing policy as a result. A change to the policy had been made to ensure that results were double checked prior to issuing a prescription when a patient was not physically present.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3. The health care assistant, practice manager and reception and administration staff members were all trained to level 1. The practice employed locum nursing staff and had a process in place to check that nurses were trained to a minimum of level 2 before undertaking any duties at the surgery and we saw evidence that these checks had taken place.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For instance, the most recent

## Are services safe?

infection control audit had taken place on 11 October 2016 and had identified that stocks of protective gloves were low. We saw that an order had been placed on the same day and stock had been delivered the next day and that a new step had been added to the infection control protocol to ensure that stocks of personal protective equipment were routinely checked.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Prescriptions which were not collected within a week were brought to the attention of the GP. The GP reviewed all uncollected prescriptions to identify any patients who might be at higher risk without prescriptions and would prioritise these patients for a follow-up call or urgent home visit. Members of the administration team then contacted all patients who had not collected prescriptions and encouraged them to do so or to confirm that the prescription was no longer required. Patient records were updated accordingly. We reviewed prescriptions waiting for collection and saw that none were more than one week old. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The Health Care Assistant was trained to administer vaccines and medicines against a patient specific prescription or direction (PSD) from a prescriber. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to

employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. Checks to ensure that electrical equipment was safe to use were overdue. The practice arranged to have these checks undertaken whilst we were at the practice and we saw evidence that these had been completed within one week. Clinical equipment had been checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.
- The practice had a process to review potential risks posed to patients when safety alerts were received from external agencies. For instance, we saw details of an alert which had been received from the Medicines & Healthcare products Regulatory Agency (MHRA) in October 2016. This related to a potential problem with implantable cardioverter defibrillators (an implantable cardioverter defibrillator (ICD) is a small device that is placed in the chest or abdomen and is used to help treat irregular heartbeats called arrhythmias). We saw evidence that the practice had undertaken an audit of records to check if any patients were affected and had reported findings back to MHRA.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

## Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents. The plan contained a section which had risk profiles and remedial actions for over 30 different critical scenarios, such as power failure, IT failure, flood or building damage. The plan included emergency contact numbers for staff and utility companies as well as full contact details for a local 'buddy' practice.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets and exception rates were comparable to local and national averages for all clinical indicators. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2014/2015 showed:

- Performance for diabetes related indicators was above the national average. For instance, 95% of patients had well controlled blood sugar levels compared to the CCG average of 83% and national average of 78%. The exception reporting rate for this indicator was less than 1% (CCG average 4%, national average 12%).
- Performance for mental health related indicators was above the local and national average. For example, 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the

record compared to the CCG average of 83% and national average of 88%. The exception reporting rate for this indicator was less than 7% (CCG average 7%, national average 13%).

- 98% of patients with hypertension had well controlled blood pressure compared to the CCG average of 88% and the national average of 84%. The exception reporting rate for this indicator was 3% (CCG average 3%, national average 3%).
- Outcomes for patients with asthma were above CCG and national averages. For instance, 94% had had an asthma review in the preceding 12 months using a nationally recognised assessment tool compared to the CCG average of 76% and the national average of 75%. The exception reporting rate for this indicator was 2% (CCG average 3%, national average 8%).

There was evidence of quality improvement including clinical audit.

- There had been five clinical audits completed in the last two years and one of these was a completed audit where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result included the introduction of an action plan to improve the diagnosis and treatment of osteoporosis amongst the practice population. During the first audit cycle, the practice had identified issues with clinical documentation, including inaccurate coding in patient records and insufficient detail of treatments provided. The practice also found that 79% of patients were receiving the recommended preventative treatment. The practice had established dedicated joint GP and Nurse annual review appointments for patients with or at risk of developing the condition. Patients who had been prescribed medium and long-term steroid treatment were invited to consultations and where appropriate offered bone protection treatment. The practice had adopted a more robust recall system for patients at risk of the condition and patients refusing the treatment were asked to attend an appointment with a GP so that the implications of refusing treatment could be fully explained. Details of all contacts with patients were fully documented and coded as necessary. The practice undertook a second audit after

# Are services effective?

## (for example, treatment is effective)

a period of two years and found that 100% of patients identified as being at risk had been prescribed with the correct treatment and that of those with steroid induced osteoporosis, 100% had been prescribed with bone protection treatment. The practice also found however that of those patients at risk of developing the condition due to other factors such as a family history of osteoporosis, only 35% had a diagnostic scan. The practice had planned a further audit after a period of six months.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the health care assistant provided day to day support to patients with long term conditions and had received appropriate training to carry out this role.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and those at risk of domestic violence or abuse.
- Smoking cessation advice was available on the premises and patients in need of dietary advice could be referred to a neighbouring practice who had in-house skills in this field.



# Are services effective?

## (for example, treatment is effective)

- Patients in need of psychological or counselling support were referred to specialist clinicians.

The practice's uptake for the cervical screening programme was 85%, which was comparable to the CCG average of 79% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Uptake rates for these screening programmes, although comparable to CCG averages were lower than national averages. For instance, only 58% of female patients aged between 50 and 70 had been screened for breast cancer in last 36 months which was the same as the CCG average but significantly below the national average of 72%. Data from the National Cancer Intelligence Network (NCIN) also showed that 30% of patients aged between 60-69 had been screened for bowel cancer in last 30 months which was comparable to the CCG average of 40% but significantly below the national average of 58%.

Childhood immunisation rates for the vaccine given were comparable to CCG/national averages. For example,

childhood immunisation rates for the vaccines given to under two year olds ranged from 96% to 100% and five year olds, with the exception of vaccination for Infant Meningitis C, from 87% to 100%. The uptake rate for Meningitis C was 24% which although slightly above the local average of 21% was significantly lower than the national average of 83%.

The practice had collaborated with other practices in the locality to produce a series of videos which promoted health screening programmes including childhood immunisations, breast cancer and bowel cancer screening. These were available in Bengali as well as English and were prominently positioned on the practice website. We were also told that the practice had undertaken community outreach with local faith based groups; for example addressing a meeting of over 300 local people to promote health screening programmes. Working in association with the locality network management, contact had also been made with a highly respected national body of a major faith group, to seek further credible support for health screening programmes and childhood vaccinations. The impact of these initiatives had not yet been measured.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40-74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in three of the four consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. The layout of one consulting room was such that it was not possible to provide a curtain and this room was locked when a GP was undertaking a physical examination. The practice had carried out a risk assessment of this procedure and as a result, had changed the lock to be keypad operated and had installed a panic alarm in the room in addition to the alarm system which was included in the practice's computer system. Before undertaking an examination, clinicians using this room would explain that the door would be locked and would offer to use an alternative consulting room if the patient was not satisfied with arrangements.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 43 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 96% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 95%.
- 82% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 82% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

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

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

## Are services caring?

- Staff told us that interpreter services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- Information about the availability of chaperones was presented in English and Bengali and details of relevant support services for patients whose circumstances could make them vulnerable was also provided in Bengali.

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

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 23 patients as carers which was less than 1% of the practice list. The practice told us they actively sought to identify carers. The registration process for new patients included questions about whether a patient was a carer for a relative or friend.

Staff we spoke with told us they would try to identify carers by observation, for instance, noting when prescriptions were routinely collected by someone other than the patient, when a friend or relative made an appointment on someone else's behalf or when patients were accompanied to appointments. Carers were offered a flu vaccination as a priority. A significant number of carers who had been identified did not have English as a first language and practice staff helped these carers to navigate support pathways and assist with the completion of forms. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, they followed protocols which reflected the patient's culture. For instance, the practice was aware that within some cultures, floral tributes or sympathy cards were appreciated but not in others, the personal attention of the GP or other surgery staff being considered more appropriate. Staff endeavoured to respect individual traditions and would attend funerals when this was appropriate. Bereaved families were offered appointments at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service, including bereavement counselling.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice 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.

- The practice offered extended opening hours on a Monday evening until 8.00pm for patients who could not attend during normal opening hours.
- Over 50% of the practice population had Bengali as their main spoken language. The practice had employed staff who were fluent Bengali speakers. In addition to Bengali, there was in-house fluency in Hindi, Gujarati, Urdu, French and Italian.
- Even though interpreter services were available, one GP had also learned to understand Bengali to ensure that patients could speak with a doctor directly and without the need to be accompanied by a family member if this was the preference of the patient.
- The practice had collaborated with other practices in the locality to produce a series of videos which provided information about managing health conditions and these were available in Bengali as well as English. For instance there were videos providing information about diabetes, chronic obstructive pulmonary disease, healthy eating and the dangers of smoking. These were prominently positioned on the practice website.
- The practice had a range of anatomical models which were used to explain conditions to patients. We saw models which were used to describe conditions which affected the musculoskeletal system as well as others which were used to explain some aspects of pregnancy.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The health care assistant visited housebound patients in their homes to support those with long term conditions and to undertake NHS health checks. The practice had carried out a risk assessment prior to providing this service. This risk assessment included a recommendation that the health care assistant should

be accompanied by another member of staff during house visits and we saw that this had been implemented and that staff asked to fulfil this function had received a Disclosure and Barring Service check.

- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- The practice was entirely ground floor based and all areas and consulting rooms were fully accessible. There were disabled facilities, a hearing loop and translation services available.

### Access to the service

The practice was open between 8:00am and 8:00pm on Monday, 8:00am and 6:00pm on Tuesday, Wednesday and Friday and 8:00am and 1:00pm on Thursday. Appointments were from 8:30am to 1:00pm every morning and 4:00pm to 6:00pm daily except Thursday when the practice was closed in the afternoon. Extended hours appointments were offered between 6:00pm and 8:00pm on Monday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 80% of patients were satisfied with the practice's opening hours which was equal to the national average of 80%.
- 81% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

# Are services responsive to people's needs?

(for example, to feedback?)

## 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.
- 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. There was a box for complaints and suggestions in reception and details of how to make a complaint were displayed in the waiting area and on the practice website and included an email address so that patients could make a complaint in private.

The practice had only recorded two complaints as received in the last 12 months. We looked at both of these and found that they had been handled in line with practice policy. We asked the practice whether all complaints were being recorded, including those made verbally. We were told that if patients were or seemed to be unhappy with any aspect of the service, staff would encourage them to engage with the complaints process but did not usually record verbal complaints as these were often resolved quickly through dialogue; although this meant that trends or patterns might not always be identifiable.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. We saw evidence that policies were regularly reviewed according to an annual schedule.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership and culture

On the day of inspection the practice management team demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the management team were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with

patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The health care assistant had qualified as a nurse in another country but was not yet registered to practice as a nurse in the UK. The practice was supporting this member of staff to undertake the necessary training and education to qualify as a practice nurse.

### Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had an active and highly organised patient participation group (PPG). The group held bi-monthly meetings which were fully minuted and had prepared an annual report detailing its scope and achievements to date. These had included working with the practice to review aspects of privacy in the waiting area which had led to improved sound proofing of consultation room doors.
- The practice had worked jointly with the PPG to carry out patient surveys and had used these to identify areas for improvement. For instance, during one survey the

# Are services well-led?

Good 

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

need for improved baby changing facilities, suitable for male and female parents and carers, had been mentioned by a number of patients. This had been prioritised and suitable provision was made.

- The practice had gathered feedback from staff through practice meetings and annual appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For instance, the practice had had an active role in the production and distribution of a series of videos which promoted health screening programmes and provided information about conditions and issues which were of particular significance to the practice population. The practice had also been active in working with local faith based groups to promote childhood immunisations and cervical screening and had achieved an uptake rate for cervical screening which was higher than local and national averages.