Dr Thyagarajagopalan Krishnamurthy

Quality Report

East Ham Memorial Hospital
Shrewsbury Road
Forest Gate
London
E7 8QR
Tel: 020 8586 6555
Website:

Date of inspection visit: 31 July 2014
Date of publication: 05/02/2015

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

Contents

Summary of findings

Overall summary

Dr Thyagarajagopalan Krishnamurthy provides a general practice service to just over 2,000 patients in the East Ham area of Newham. There is one GP, a part time salaried GP and part time nurse.

We carried out an announced inspection on 31 July 2014. We spoke with 14 patients during our visit and received 44 comment cards completed by patients who visited the surgery during the two weeks before our visit. Patients comments about the care and treatment they received were positive, they felt they were respected, their dignity and privacy maintained and said staff were kind, caring and helpful. The few negative comments were about the environment, getting through on the telephone to make an appointment and having to wait when they attended their appointment. We met with NHS England and Newham Clinical Commissioning Group before our visit.

The practice had a higher than national and local average number of older patients. The practice had a named GP for patients over 75 and a system to review medication at least annually to ensure it remained appropriate. The practice was accessible to patients with mobility issues and those who used a wheelchair. The practice kept a register of patients with long term conditions and suitable systems in place to review treatment plans to check they were working and no new conditions were developing. There were suitable child protection procedures and staff were trained to the appropriate Level and aware of their responsibilities to report issues and concerns. The practice offered health checks and immunisations in line with the 'healthy child programme'. The CCG had identified two local GP practices to provide services to patients who were homeless and while Dr Krishnamurthy was not one of these, he said he would see patients if it was urgent. There were regular meetings with the local mental health services to provide joined up care to people experiencing poor mental health.

The provider was in breach of regulations related to: staff recruitment because records did not confirm that the required checks had been made (lack of references, proof of identity and Disqualification and Barring Scheme checks); management of medicines because we found out of date medicines and emergency medicines (limited recording of fridge temperatures) and cleanliness and infection control because there was no written cleaning schedule and details of cleanliness checks to made. Improvements were required to the systems for reporting incidents to ensure all significant events were recorded and the learning could be shared with all staff. A safeguarding vulnerable adults policy must be in place.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice required improvements to ensure patients were protected from avoidable harm.

Arrangements for reporting incidents were not effective. There were at least four incidents that we were told about during the inspection that had not been recorded as significant events. This meant staff were not aware of these incidents and could not learn from the experience. The reporting process did not include notifying the Care Quality Commission (CQC) as required.

The doctor received safety alerts, although there was no system to share these with the salaried GP and other staff, with no records kept to show these had been acknowledged and acted upon.

Policies were in place and staff had completed training to the required Level in child protection and staff were aware of their responsibilities. Staff had completed training in safeguarding vulnerable adults although there was no policy and staff were not fully aware of who was considered a vulnerable adult and what they needed to be alert for at the practice. There was a panic alarm for staff to summon help if required, although not all staff were aware of where the buttons were and the actions they should take if the alarm sounded.

The systems in place to check medicines were not sufficient because we found out of date medicines and the records were not complete.

While we saw the practice was clean and staff had completed training in infection control, there was no cleaning schedule and no checks of cleanliness were carried out. There was a lack of infection control audits and the policy was in a number of different places making it not easily accessible to staff.

Recruitment records were not available for two members of staff and other records did not indicate that the required checks had been completed before staff started work at the practice.

While staff were trained in basic life support and equipment was in place to deal with medical emergencies, we found out of date medicines and the automated external defibrillator (AED) was still in the box, not attached to the wall.

Are services effective?

The practice required improvement to ensure patients received effective services.

Summary of findings

The doctor kept up to date with best practice standards and guidelines and used them to develop treatment plans. However, there were no systems to share information, a lack of clinical audits and no peer review system in place. There were appropriate systems to manage health reviews for patients with long term conditions. There were links with other health and social care services although they were not all formalised with regular minuted meetings. Staff had access to the training they needed. However the appraisal system was not consistent.

Are services caring?

The practice provided a caring service.

Patients were treated with kindness, dignity and respect. We saw interactions between staff and patients were positive, staff were respectful and helpful and clearly knew patients well. Patients we spoke with made positive comments about the service they received and said staff were friendly and the doctor was caring. Comment cards we received indicated patients were happy with the care and treatment they received.

Staff involved patients in care and treatment. Suitable systems were in place to seek consent before patients received treatment and the doctors were aware of the legal requirements when patients did not have capacity to consent.

Are services responsive to people's needs?

The practice was responsive to patient's needs by knowing the health needs of the local population and providing a range of appointment times and providing interpreters to meet those needs. While there was a Patient Participation Group (PPG) in place, it was for a number of practices in Newham and there was little evidence of the practice responding to patients' feedback. The service was accessible to people with mobility issues and those who used a wheelchair. There was a suitable complaints process in place, although some patients we spoke with were not aware of how to make a complaint.

Are services well-led?

The practice required improvement to provide a well led service.

There was a lack of risk assessments and audits, and the arrangements for reporting incidents, managing medicines and cleanliness were not suitable.

Summary of findings

There were clear lines of responsibility with the doctor being the lead for safeguarding, infection control and complaints and staff were clear about their roles and responsibilities. The practice ethos was caring and responsive and patients were positive about the care and treatment they received.

Summary of findings

The six population groups and what we found

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

Older people
The practice provided effective, caring and responsive services to older people. There was a named GP for patients over 75 to ensure continuity of care and treatment was provided. Improvements could be made to the safety of older patients by the provision of a safeguarding vulnerable adults policy and improved staff awareness of patients who may be considered vulnerable.

People with long-term conditions
The practice provided effective, caring and responsive services to patients with long term conditions. There was a register of patients with long term conditions which enabled the practice to carry out regular medication reviews to ensure treatment remained appropriate. A number of clinics were provided for patients with long term conditions. However, improvements were required to the systems for clinical audits and undertaking reviews of the services provided.

Mothers, babies, children and young people
The practice provided effective, caring and responsive services to mothers, babies, children and young people. Suitable policies and procedures were in place for child protection, and the appointment system enabled the doctor to see children on the day if the need was urgent. There were clinics and appointments for child health checks and immunisations to meet the 'healthy child programme'.

The working-age population and those recently retired
The practice provided effective, caring and responsive services to working age patients and those recently retired through the provision of extended hours appointments.

People in vulnerable circumstances who may have poor access to primary care
The practice provided effective, caring and responsive services to patients in vulnerable circumstances who may have poor access to primary care. While the CCG had identified two GP practices where patients who were homeless were able to register and get their health needs met, the doctor said he would see patients if they attended and needed urgent care and attention.

People experiencing poor mental health
We found the practice provided caring services to patients who experienced poor mental health. There were arrangements for

meetings with the local mental health services, although records were not kept of discussions. The doctors were aware of their legal responsibilities regarding consent and patients' capacity to make decisions and were involved in best interest decisions when required.	

Summary of findings

What people who use the service say

We spoke with 14 patients during our visit and received 44 comment cards completed by patients who visited the practice during the two weeks before the inspection.

Patients we spoke with said they were very happy with the care and treatment they received. They were complimentary about the care and the service staff were providing saying that staff were good, reception staff were very helpful and the doctor listened and had time to deal with their concerns. Most patients had not experienced difficulty getting through to the practice to make the appointment and they had not waited too long to see the doctor on the day we spoke with them.

Patients did make a few negative comments, mainly related to the environment. One suggestion was that the place could be brightened up by being repainted. Another comment was that the waiting room could benefit from fans, especially when it was very hot. Another comment was about the information provided in the waiting room, of which there was a lot, most of it written in English, although there were some leaflets in other languages. It was suggested that this information would reach a wider audience and more of the local community if it was available in more than one language.

Patients said the repeat prescription process was clear, convenient and that they got their prescriptions in a timely manner. Some patients reported long waits for referrals, although they understood this was not the doctors fault and knew reception staff had chased appointments in some circumstances. Patients said the process for blood tests was satisfactory. The doctors said they sometimes relied on patients to report back to them any concerns or issues, which was not ideal.

Responses in 43 of the 44 comment cards received indicated patients were happy with the services provided. They said staff were kind, caring, friendly and helpful; they felt listened to and said they had the time they needed to explain their ailments to the doctor. They said staff and the doctors treated them respectfully and maintained their privacy. Four patients said they had no complaints about the practice. Four patients commented that they got the right treatment at the right time. There were negative comments in seven of the 44 comment cards received; three of those noted that it was difficult getting through on the telephone to make an appointment and one the difficulty in getting an appointment. Another comment was around the long wait they experienced once they had arrived for their appointment.

Comments from the GP survey completed in 2013 showed 92% of respondents had confidence in the doctor, 81% said their overall experience was good and 74% would recommend the practice to new people to the area. 86% of respondents said the doctor was good at listening to them and 83% said the doctor was good at explaining tests and treatments. Similar levels of satisfaction were reported about the nurse. 70% of respondents said they usually waited 15 minutes or less when they attended for their appointment.

Areas for improvement

Action the service MUST take to improve

- the practice must ensure there is a cleaning schedule in place with records of regular cleanliness checks;
- staff recruitment records must demonstrate that the required checks were completed on all staff;
- systems must be in place to ensure emergency medicines and vaccines are replaced before their expiry date.

Action the service SHOULD take to improve

- develop a regular cycle of clinical audits with a system to share the findings of audits with staff;
- patients should be made aware of how to make a complaint;
- systems should be developed to share feedback from the PPG to other members and staff;
- review of the use of the electronic appointments system;
- develop a system to check urgent referrals;

Summary of findings

- a safeguarding vulnerable adults policy should be developed;
- the lack of privacy at the reception desk should be reviewed;
- a system to notify CQC of incidents and events as required;
- review policies and procedures to ensure they are accessible to staff and
- ensure all staff have annual appraisals of their work.

Dr Thyagarajagopalan Krishnamurthy

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by a second CQC inspector and two specialist advisers, one a GP and the other with wide experience in practice management.

Background to Dr Thyagarajagopalan Krishnamurthy

Dr Thyagarajagopalan Krishnamurthy is a single location practice which has been based at East Ham Hospital for eight years and was previously at a temporary surgery in the local area for six years. The building was purpose built as a medical centre in 1929 and is a listed building. It has undergone some conversion work and houses a variety of community services including district nurses and another GP practice. Dr Krishnamurthy is registered to provide the regulated activities: treatment of disease, disorder and injury, diagnostics and screening procedures, maternity and midwifery services and surgical procedures. The doctor told us that he is no longer carrying out minor surgery.

The practice has one full time GP and a part time salaried GP who covers four morning sessions each week. A nurse is employed part time covering two mornings and one afternoon a week and a health care assistant is at the surgery one day a week. There is a part time senior receptionist and three part time reception/administrative staff.

They provide a general practice service to just over 2,000 patients who live within a one mile radius of the surgery for people with a postcode of E6, E7 and E12.

The practice is open Monday to Friday 09.00 – 13.00 and 14.00 – 18.30 with appointments available Monday, Wednesday and Friday from 09.00 – 11.00 and 16.30 – 18.30, Wednesday 09.00 – 11.00 and 16.30 – 20.00 and Thursday 09.00 – 12.00.

The practice provides clinics for asthma, child health and development and immunisations, chronic obstructive pulmonary disease, smoking cessation and travel health including vaccines.

Dr Krishnamurthy had opted out of providing an out of hours service. This service is provided by Newham GP Co-Operative Ltd.

Local hospital services were provided at Barking, Havering and Redbridge NHS Trust, Barts Health NHS Trust or Basildon and Thurrock NHS Trust. Community and mental health services are provided by East London NHS Foundation Trust.

Newham is the second most deprived out of 326 local authorities, with 71% of the population belong to non-white minorities, which is almost five times the national average. Drug misuse, recorded diabetes, incidence of tuberculosis and acute sexually transmitted

diseases are significantly worse in Newham than the national average. There are higher rates of unemployment than the London average and it has the 10th highest suicide rate in London.

While Newham had a higher percentage of children and lower number of people over 65, this was not the case for Dr Krishnamurthy where a third of the patients were over 65 years and under a quarter were under 19.

Only 79.5% of the population in Newham were registered with a GP. Arrangements were in place for two GP practices to accept patients who were homeless and did not have the proof of address documents required to register. This information was displayed in the practice waiting room for patients who were looking to register but did not have the required documentation.

Before our visit we met with the CCG, NHS England and Healthwatch, to share what they knew about the service.

We spoke with 14 patients, and a representative from the PPG, five members of staff including the two GPs and reviewed a range of records including staff recruitment and training files, health and safety checks, infection control audits, significant event records, clinical audits, complaints and policy documents. We checked storage arrangements for records and medicines. We observed how staff interacted with patients and inspected the premises.

Why we carried out this inspection

We carried out this inspection 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 was meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new process under Wave 2. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we analysed data from our Intelligent Monitoring system. We asked other organisations, NHS England, the Clinical Commissioning Group and Healthwatch to share their information about the service. This did not highlight any significant areas of risk across the five key question areas.

We carried out an announced visit on 31 July 2014 between 9.00am and 7.30pm. During our visit we spoke a range of staff including two GPs, the senior receptionist and two reception staff. We spoke with 14 patients who used the service and a representative from the patient participation group (PPG). We observed how patients were being cared for, looked at records including clinical audits, significant events, staff recruitment and training files, health and safety checks and equipment maintenance, complaints and policy documents. We looked at how records, medicines and equipment were stored. We reviewed 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

Arrangements for reporting incidents were not effective, because not all incidents had been recorded. The doctor told us there were issues with the recording on the blood monitoring machine some months ago and while this had been fixed, it was not recorded as an incident. Another example was when a patient attended concerned about the name of a medicine they had been prescribed. On investigation, the doctor found the wrong medicine had been dispensed and while the medicine had not been taken and the correct medicines were prescribed, the actions were not recorded. The process did not include notifying the Care Quality Commission (CQC) as required. Staff we spoke with were clear about their role and would report issues, concerns and incidents to the doctor.

Learning and improvement from safety incidents

Whilst the practice had a system in place for reporting, recording and monitoring significant events, we saw no evidence that it was used and followed. We were initially told that there had been none during the last year. However we were told about a number of incidents and events that had occurred that on reflection the doctors said were significant events. This meant that the process for reviewing and learning was not completed and details were not shared with staff.

Staff spoken with were aware of the incidents and changes that had been introduced to prevent recurrence. One incident had led to the development of a new induction process for locum doctors, to ensure they knew where everything they may need was located within the practice. After an incident regarding new patient registration, a poster in English was displayed at reception informing potential new patients of the documents they needed to bring when they registered and directing them where to go if they did not have the required documentation. There had been two incidents when there had been a complete power failure. An emergency protocol was in place and we saw actions were taken to move medicines to another building to ensure they remained at the correct temperature. Staff contacted another practice to access the patient appointment list and systems were put in place to ensure records were maintained. Another incident identified a need for two staff to be at reception at all times and panic alarms were fitted and additional locks were fitted to prevent people entering the practice from other parts of the building.

The doctor received patient safety alerts from the Medicines and Healthcare Products Regulatory Authority and NHS England electronically, although there was no system for these to be printed or to be shared with the salaried GP and other staff. There was no record of the effect of safety alerts on the practice.

Reliable safety systems and processes including safeguarding

Child protection policies were in place and staff had completed training to the required Level in child protection. Reception staff were trained to Level 1, with the doctor and salaried GP at Level 3. Staff spoken with were aware of their responsibilities to report incidents or concerns. The doctor was the safeguarding lead and all staff said they would report concerns to him. The doctor described the referral process to social services, although said he had not made one for some time.

The electronic recording system had an 'alert' that would indicate if a child was subject to a child protection plan which ensured staff were aware when there were concerns. The doctors said they did not attend case conferences but would usually receive minutes of meetings and be kept updated with changes.

There was no policy for safeguarding vulnerable adults. The salaried GP and reception staff had completed training in safeguarding, although not all staff were able to state who might be a vulnerable adult and the issues they needed to be aware of at the practice.

There was a panic button in reception and the doctors' and nurses' consultation rooms for staff to use to summon help. While the alarms had been tested, not all staff were aware of where the buttons were sited and the actions they needed to take if the alarm sounded.

The practice had a chaperone policy; this is when the nurse or other member of staff sit in with a patient during their appointment. Staff who undertook chaperone duty had been trained and had a Disclosure and Barring Scheme check. There were notices informing patients that this service was available.

Are services safe?

Monitoring safety and responding to risk

Written risk assessments were not in place, although staff were clear about some of the risks and actions they needed to take to keep themselves and patients safe.

Policies and procedures were in place for fire safety, health and safety and infection control, although there was no index and they were not easily accessible.

There was a business continuity plan which included the actions staff should take in unforeseen circumstances to ensure the service continued to operate.

Medicines management

Whilst medicines were suitably stored in a room which was secured by a key pad entry system, we found some out of date emergency medicines, syringes and needles and alcohol wipes which were removed and disposed of safely during our visit.

The auditing of emergency medicines were on a piece of paper which could lead to confusion and errors and be easily lost. Although we were told medicines were usually checked by the nurse who had not been at work for two weeks so there may have been a more robust recording system in place.

There were out of date vaccines in the medicine fridge which were removed and disposed of. The vaccines fridge temperature auditing was completed daily by the acting practice manager and recorded on a paper log stored nearby. The provider may wish to note that there was no functional auditing structure to the document; it was a piece of paper with hand written daily notes recording the date, time and temperature.

Cleanliness and infection control

We found the practice environment was clean. Patients said the practice was always clean when they visited. There were suitable facilities for hand washing in consultation rooms and hand gels were available.

A cleaner was employed for three hours three days a week and reception staff said they would empty rubbish bins and deal with any spillages on other days if required. The doctor told us that he was the infection control lead and responsible for telling the cleaner the areas to be cleaned. However there was no written cleaning schedule and no records to show cleanliness checks of the environment were completed as described in the Department of Health Code of Practice on the prevention and control of infections.

There was an infection control policy from the Primary Care Trust (PCT) dated 2012 and another policy document from a local GP and a document which identified actions staff should take to deal with spillages including bodily fluids. These documents were not kept together and may not have been easily accessible to staff if needed. The PCT completed an infection control audit in 2011 which identified some areas for improvement including the practice developing a policy, records to be kept of cleaning required and completed and staff training. While some areas had been addressed it was not clear if all had been completed.

Reception staff had completed training in infection control and were aware of how to deal with samples safely. There was a supply of personal protective equipment available to reception staff when required. We were told that most patients took their samples to a local clinic rather than the practice.

Clinical waste was stored separately and disposed of safely with appropriate contracts in place for removal. The yellow bin was locked but not secured outside the building. The doctor told us this was due to the contract with the owners of the building. Sharps boxes in use did not have the date they were started recorded on them.

Staffing and recruitment

The recruitment policy indicated that the required checks were carried out before new staff started, with references taken up, Disclosure and Barring Service (DBS) checks and proof of identity required. However, the staff files seen did not include evidence that these checks had been completed for all staff currently employed and there were no recruitment records for two members of staff.

One staff file contained a reference dated 2010, although the member of staff started work at the practice in 2012. References were not present in the other five staff files seen. Proof of identity was not seen in any staff files and contracts of employment were seen in two out of six staff files. There was a DBS check in three of the six files seen; while two of these were administrative staff who were in post before the practice was registered with the CQC so this check was not required, one was clinical staff who saw

Are services safe?

patients. The recruitment file for the nurse contained evidence that they were registered with the NMC and the salaried GP was on the performers list (this is the list of GPs that are registered and have gone through certain checks).

Dealing with Emergencies

There was adequate equipment to deal with foreseeable medical emergencies, although as previously mentioned there were some out of date emergency medicines that were disposed of. There was oxygen and an automated external defibrillator (AED). However, the AED was unopened and still in its packaging, rendering it effectively unavailable in the event of a genuine emergency. Staff were trained in basic life support and had received training in the use of equipment available.

Equipment

Staff said they had access to sufficient equipment at the practice. Regular checks were completed for equipment in use at the practice.

Suitable arrangements were in place to ensure annual checks of portable electrical appliances, fire extinguishers and the fire alarm system were completed. There were no records of fire drills, although the alarms sounded and people evacuated the building during our visit.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The doctors kept up to date with best practice standards and guidelines. They had links to the National Institute for Health and Clinical Excellence (NICE) guidance on the internet and attended training sessions arranged by the Clinical Commissioning Group (CCG). However, there were no arrangements for the doctors to meet to discuss the impact of changes for example around new treatments or changes to prescribing. The doctors used the British National Formulary (BNF) to check medicines and dosage required.

While the doctors had not completed formal training on The Mental Capacity Act (2005), they were able to describe how they assessed a patient's ability to give consent and the actions they would take if a patient was not able to consent. We were given examples of best interest decisions that doctors had been involved in with carers, health and social care professionals to ensure a patients needs were met.

Patient records were stored on computer systems with a paper copy stored securely in a room which had a keypad entry system.

Suitable arrangements were in place for patients to be referred to other health and social care services when required.

Management, monitoring and improving outcomes for people

The doctor was clear about where the practice stood in relation to the Quality and Outcomes Framework (QOF), the voluntary incentive scheme used to encourage high quality care, with indicators used to measure how well practices are caring for their patients. Information from the practice was reviewed by the Clinical Commissioning Group (CCG). However, there was no system to share this information with the salaried GP.

There was no regular system for completing clinical audit cycles which meant the practice could not demonstrate how they improved outcomes for patients. The salaried GP conducted an audit of a medicine used to treat obesity in December 2013 and demonstrated the changes made to treatment regimens following this audit. However, there was no system for this information to be shared with the doctor.

The doctor reported they had informal links with three other local practices although this had not included any peer review processes.

The practice was registered to undertake minor surgical procedures although the doctor told us he no longer carried out this service.

Effective Staffing, equipment and facilities

The staff recruitment process included checks on clinical staff qualifications to make sure they were suitably qualified to carry out their role. Staff told us their induction gave them the information they needed, although records of induction were only in place for one member of staff. Staff told us they were up to date with their mandatory training. Records showed staff had completed the training required for their role including basic life support, infection control and fire safety.

In addition, staff had received training in Co-ordinate My Care (for patients receiving end of life care) and Carer Awareness to help them understand the needs of carers so they could respond appropriately. The doctor had signed up to a local enhanced service (this is a service agreed by the CCG in response to local need) for Tuberculosis. We saw staff had completed training to help them carry out this service.

From records and discussions with senior staff, it was not clear exactly when the practice manager had retired or left the practice. While arrangements were in place for a member of staff to cover this role, they worked fewer hours and they still had their own work to complete. We saw this impacted on the level of support provided to staff and the lack of organisation of records in particular policies and procedures.

While staff told us they felt supported in their role, records indicated that the appraisal system was adhoc rather than something that happened annually. Three members of staff had an appraisal in 2011 and again in 2014 and one member of staff had no appraisals recorded.

Are services effective?

(for example, treatment is effective)

The doctor told us he was up to date with his appraisal and was preparing for revalidation in 2015. The salaried GP had been appraised and due for revalidation in 2015. (Revalidation is the process by which doctors demonstrate they are up to date and fit to practise).

The nurse had been off sick for two weeks and we were told this may continue for a further two weeks or longer. At the time of our visit the doctors were covering the nurse's role and suitable arrangements were in place for the position to be covered if she did not return to work at the expected time.

Working with other services

Suitable systems were in place for the out-of-hours service to send records of patients seen at weekends and out-of-hours, which were checked by the doctor each day.

While they were not required at the time of our visit, the doctor told us they used special patient notes for patients receiving end of life care to ensure all doctors and the out-of-hours service had access to the most up to date information to meet the individual's needs.

Suitable systems were in place to follow up referrals to ensure patients saw other health professionals in timely manner. However the system to receive feedback from health professionals was more adhoc: the doctor said they often relied on patients reporting back at their next appointment.

Discharge letters, test results and information from other health and social care providers were seen by the doctor and scanned onto the electronic patient records, with a copy kept in the paper file should it be needed in the future.

The doctor reported regular contact being held with the mental health team, although meetings were not recorded. The doctor attended monthly meetings with the CCG. The pharmacist visited regularly to provide information and advice. The systems in place to communicate with other health professionals including health visitors and district nurses were on an as required basis rather than through regular minuted meetings.

Health Promotion & Prevention

All new patients received a new patient check which included attending for routine checks and a medical and social history being taken. Health advice was given to patients and health screening could be targeted to those patients at risk of developing certain health conditions. Staff told us that if new patients did not attend the practice for this check, they would not be registered.

The practice provided clinics for patients with asthma, breathing disorders and smoking cessation. There was a range of information leaflets in the waiting room for patients, although patients we spoke with told us they did not look at the information and use it to help improve their health. The majority of information and leaflets were written in English, which was not the first language of a large number of patients. Staff told us that they had some leaflets in the most common languages used by patients, which were given to patients when required.

Patients we spoke with said the doctor and nurse spoke with them about maintaining a healthy lifestyle including diet, exercise and not smoking.

Arrangements were in place for screening and vaccinations to be given to patients when required. The doctor reported 96% of women aged 25 – 64 years of age attended for smear tests, although there were no audits to confirm this.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients that we spoke with told us that they were respected, treated with dignity, were informed and involved in their care and treatment, and that choices on offer were understood and explained.

In 41 out of 44 comment cards we received patients were happy and satisfied with the service they received, they said the service and treatment provided were good and they felt listened to, treated fairly and with respect. Comment cards indicated that patients thought staff were friendly, kind, caring, helpful, welcoming and polite and the doctors was caring and provided good treatment and medicines. Three patients noted that they got appointments when they needed to, that the opening times were good and that the extended opening hours were helpful for those who worked.

During interactions between patients and staff we were able to see that all were compassionate, courteous and respectful. Staff clearly knew patients, calling them by their names, holding doors open and walking down the corridor to the doctor's room if they needed support.

The waiting room was shared with another practice, and the reception area was partially open which meant patients waiting could overhear conversations from both practices, both with other patients signing in and when staff were on the telephone. There was an electronic signing in system, although most patients we spoke with preferred to speak with reception staff when they arrived for their appointment. Staff were aware of the need to maintain privacy and told us they had separate rooms if they needed to have conversations with patients, although they said that this was more difficult when patients had telephoned the surgery.

Staff told us that there was a process for new patients to attend an initial check as part of the registration process, and if new patients did not attend this check, they would not be registered.

Results from the GP Survey 2013 indicated that patients were satisfied with the treatment they received. 92% of respondents said they had confidence in the doctor, 81% said their overall experience was good and 74% would recommend the doctor to people new to the area. 86% and 83% said the doctor was good at listening and explaining tests and treatments to them, while 83% and 86% said the nurse was good at listening and explaining. 64% of respondents said they usually saw their preferred doctor. This number of positive comments was above average for the CCG area.

Involvement in decisions and consent

Patients told us that they felt listened to and involved in the decisions about their care and treatment and were given information about how to manage a healthy life style.

The doctors were clear about consent and said they seek verbal consent for examinations. They said they spoke with parents to seek consent before treating children. Patients confirmed that they were asked consent and given choices in treatment. The doctors were aware of the need to use their professional judgement to decide if young people were able to consent to treatment themselves.

We saw a Mental Capacity Guide and while the doctors had not completed specific training around the Mental Capacity Act (2005), they were aware of and had been involved in the process for best interest decisions.

While there were no patients receiving end of life care at the time of our visit, there were processes to follow should this be required. The doctor would refer the patient to the community matron and community team who work with the patient and their family. The doctor gave examples of information and support being given to carers and family members during the end of life period. The doctor would complete do not resuscitate forms where relevant in consultation with the patient.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

There was a Patient Participation Group (PPG) in place which was a joint one across a number of practices in Newham. We spoke with a representative of the group during our visit who had attended meetings and felt the group was representative of the population in the local area. We were later shown minutes of meetings and outcomes of patient surveys. These showed patients had made suggestions to improve the waiting room with music or television, redecoration and the provision of more toys for children. However, there was no evidence that these suggestions had been followed up. The group had discussed issues with the number of patients who failed to attend appointments and in response to this, the practice sends text reminders of appointments to patients. The doctor told us that due to the contract they were not able to make certain changes to the building and needed specific permissions for example before they hung things on the walls. There was no system to feedback information from the PPG to patients and staff.

The salaried GP said the practice was set up for people who use the service, particularly those from the local area with access to translators, systems for referrals, information about local support groups and health and well-being information provided. The doctor demonstrated detailed knowledge about the patient population and their needs and how they differed from other practices in the local area with their higher than average number of older people and lower numbers of children on the register. The doctor met with the CCG every month.

Access to the service

Reception was staffed between 09.00 and 12.00 on Thursday and 09.00 and 13.00 and 14.00 and 16.30 other weekdays. The practice offered appointments Monday, Tuesday, Wednesday and Friday between the hours of 09.00 and 11.00 and 14.30 and 18.30, between 09.00 and 11.00 on Tuesday and 09.00 and 12.00 on Thursday and offered extended access on a Tuesday evening between 18.30 and 20.00. The practice offered emergency appointments on the same day for urgent concerns and there were three appointments available to be booked in advance. Patients we spoke with were satisfied with the arrangements to be seen quickly. The doctors said reception staff were good at ensuring emergency appointments were used appropriately. Staff sent text reminders to patients to help reduce the number of missed appointments.

The doctor provided telephone consultations if required. Home visits could be arranged for patients who were unable to attend the surgery due to their medical condition; the doctor decided who fitted this criteria on an individual basis.

The doctor did not provide services out of hours, these were provided by a local GP Co-Operative. The details of this service were included in the practice leaflet and the phone number was on the practice recorded telephone message.

In addition to telephone bookings, patients could use a form on the practice website. Although this was relatively new and there was no process to review if the system was working for patients.

In the 44 comment cards we received, three patients told us they had trouble getting through to the practice on the telephone to make an appointment and one patient said that appointments did not run to time so they waited to see the doctor when they attended. Some of the patients we spoke with during our visit said they had experienced difficulty getting through on the telephone to make the appointment and had waited to be seen, although they did not see this as an issue.

The system for repeat prescriptions was satisfactory and patients said it worked for them. Requests were made in person, by post or at the chemist and the prescription could be collected from the surgery or at the chemist.

The building was accessible to people with mobility issues and those who used a wheelchair. The practice shared a waiting room with another doctor's practice and was on a large site providing other health services. The signage for other services provided on the site was not clear, during our visit we saw people come to reception when they wanted another service. Staff told us this happened frequently and they were used to re-directing people to the appropriate service.

Meeting people's needs

The doctors spoke four languages in addition to English so could interpret for some patients. The doctors and staff said they had access to telephone interpreting services and

Are services responsive to people's needs?

(for example, to feedback?)

could book an interpreter if required, although they said that patients often brought someone with them who could help them understand what was being said. Some patients we spoke with told us they preferred to bring a relative to interpret.

Some information leaflets were provided in the different languages used by local people. Reception staff said they could access more leaflets in other languages if required.

The doctors used the 'choose and book' system for patient referrals to other health professionals, (this is when the patient chooses the hospital they wish to be referred to and can book their own date for appointment). When the need for referral was urgent, they used the two week wait process. There was no system for the practice to check that urgent referrals were processed and patients had accessed the other services required. The doctor said they waited for feedback from patients for some referrals.

Concerns & Complaints

The practice had policies and procedures for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The doctor was the responsible person who handled complaints in the practice. Information on how to make a complaint was included in the statement of purpose and practice leaflet that was available to patients and the process was displayed on a notice board in the waiting room. However some patients we spoke with were not aware of how to make a complaint, although they said they would speak with reception staff or find out how to complain. Records were kept of complaints, we looked at the one received which indicated the practice had responded appropriately and there were no actions to be completed.

Are services well-led?

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

Our findings

Leadership & Culture

The doctor had a clear vision to provide patient care in a clean, suitably equipped and safe environment working with other healthcare providers to ensure appropriate and cost effective pathways were provided for patients close to home. The Statement of Purpose detailed this information. However, this had not been shared with the salaried GP. The doctor discussed his succession plan for the future of the practice. Staff were clear about their roles and the leadership of the service and worked well together.

Governance Arrangements

The doctor was the infection control and safeguarding lead and had overall responsible for the smooth running of the practice. Staff were clear about their role and that they reported to the doctor who dealt with issues and incidents.

We saw practice meeting minutes for February, April, June and July 2014. These were attended by the doctor and reception staff and detailed recalls, child immunisations and QOF information.

Systems were not in place to ensure staff received an annual appraisal.

Systems to monitor and improve quality & improvement (leadership)

Regular clinical audits were not completed and those audits that had been completed were not always shared between the doctors. There was no system for the practice to take part in peer review.

The doctor attended monthly meetings with the CCG and was clear about how they were performing with QOF.

Patient Experience & Involvement

The salaried GP had completed some patient surveys as part of their appraisal and told us that no issues were raised.

Patients we spoke with during our visit and in comment cards received included positive comments about the care and treatment they received. The negative comments patients made were about the environment and getting through to the practice on the telephone. The doctor was aware of these issues, although he told us that changes to the environment were difficult to negotiate and there had not been a review of the telephone system.

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

The PPG were involved in patient surveys and the feedback included suggestions to improve the environment. There was no evidence to show that patient suggestions to have a television, music, more toys or for the place to be repainted. We discussed this with the doctor who explained the issues with the environment He explained that because of the age of the building it is listed which meant there were strict limitations for changes and any requests for simple things like putting a notice board on the wall required permission to be sought which took time. There was no formal system to feedback findings from the PPG to staff.

Staff meetings were held regularly. Arrangements for staff training were appropriate. There was a whistleblowing policy in place.

Management lead through learning & improvement

The doctor provided clear leadership, was aware of his responsibilities and staff reported issues, concerns and positive comments to the doctor. Whilst there were systems in place to learn from incidents and complaints, we saw no evidence that these were used. There was no system of regular clinical audits or peer review to ensure improvements to treatment provided.

Identification & Management of Risk

The practice monitored quality against the QOF indicators to improve services for patients. This was discussed at staff meetings.

While policies and procedures were in place there was a lack of written risk assessments.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The number of patients over 65 registered at the practice was above the national and CCG average.

While staff had completed training in safeguarding and were aware of the signs of abuse, they were not all aware of patients who may be described as vulnerable and the practice did not have a policy. This may mean staff would not realise a patient was vulnerable and may not report their concerns to the doctor.

All patients over 75 years of age had a named GP and received regular health checks. Systems were in place to ensure regular medication reviews were carried out to ensure treatments remained appropriate. Patients we spoke with were satisfied with the systems in place for repeat prescriptions. The practice contacted patients who were eligible for the flu and shingles vaccines to increase the uptake. While there were no patients receiving end of life care at the time of our visit, the practice used special patients notes and suitable arrangements were in place to liaise with other community services to ensure patients received joined up care and treatment.

The doctor was aware of patients who had caring responsibilities and was able to offer support and direct them to appropriate local support services when required.

Patients made positive comments about the care and treatment they received.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The doctor knew the number of patients with learning disabilities and dementia and other long term health conditions and told us there was a register or these patients. Arrangements were in place for regular medication reviews to ensure treatments remained effective. Suitable systems were in place to make referrals to other health services when required. The practice provided specific clinics for asthma, chronic obstructive pulmonary disorder (COPD which is breathing difficulties) and smoking cessation to support patients with long term conditions. Home visits could be arranged for patients who were unable to attend the practice. The practice was signed up to a local enhanced service (this is a service agreed by the CCG in response to local need) for patients with tuberculosis and staff had completed training to ensure they were able to meet these patients specific needs. The doctor reported regular meetings with other health care professionals including community nurses to provide joined up care to patients.

Patients we spoke with made positive comments about the treatment they received and the way staff responded to them.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

Suitable policies were in place for child protection and staff had completed training to the required level and were aware of their responsibilities to report concerns to the doctor.

A nurse was employed for two and a half days a week. The practice provided child health and development and immunisation clinics for babies and children in line with the 'healthy child programme'. So children received preventative treatment. There was a system for new mothers to receive the six week post natal check. This included a check for depression which meant appropriate support, referrals and treatment could be provided when required.

Patients told us the doctor was good at explaining treatments in ways children understood.

The practice made arrangements to see children on the same day for urgent concerns. The practice worked with other health and social care professionals to provide joined up treatment and care for patients. There were no children with disabilities going through transition although the doctor was aware of the process and the need for good joined up working to ensure the patients' needs were met.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice provided extended hours appointments to enable patients who worked to access the service without taking time off work. They could also have telephone appointments to save attending the surgery if the doctor felt it appropriate. A travel clinic provided patients with information they needed and immunisations required before travelling abroad.

The system for text reminders for appointments was useful for patients who made appointments in advance to prevent 'missed' appointments.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

Newham CCG had identified two GP practices where patients who were homeless were able to register and get their health needs met. However, the doctor told us that he would see a person who was not registered and did not have the appropriate documentation to register who presented at reception and was not well.

There was a list of patients with learning disabilities and systems were in place for them to receive an annual health check as required.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The doctor had regular meetings with the local mental health team, although minutes were not kept. While the doctors had not completed specific training in the Mental Capacity Act (2005), they were aware of their legal responsibilities regarding consent and the four questions to be covered when ascertaining if a patient was able to give consent. They described instances when they had used best interest decisions to ensure patients received treatment when they were not able to give consent. The doctors told us that they would involve a patient's psychiatrist if one was involved.

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
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The provider did not have suitable arrangements in place for staff recruitment. Records in place did not confirm that the required checks had been completed before staff started work. Regulation 21 (a)(i)(ii) (b).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The provider did not protect service users against the risks associated with medicines. Regulation 13.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: The provider did not have suitable arrangements in place to protect people who use the service and staff from the risks of infection. Regulation 12 (2)(c)(i).