Dr Altafuddin Ahmed

Quality Report

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

Contents

Summary of findings

Overall summary

Dr Altafuddin Ahmed is a GP service located in the London Borough of Newham. This is the only location operated by this provider. Dr Altafuddin Ahmed is registered with the Care Quality Commission (CQC) to provide three regulated activities: treatment of disease, disorder or injury; family planning; and maternity and midwifery services at one location.

The regulated activity of diagnostic and screening procedures is also provided but Dr Altafuddin Ahmed is not registered to provide this. This is being followed up and we will report on any action when it is complete.

During our inspection visit which took place over one day, we spoke with three GPs, two practice nurses, one healthcare assistant, the practice and deputy practice managers and four administrative staff. We spoke with six patients and three members of the practice's patient participation group (PPG).

We liaised with the East London Clinical Commissioning Group (CCG), NHS England and Healthwatch Newham.

Dr Altafuddin Ahmed provided a caring service. Although patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice on a day to day basis, significant improvements were needed to ensure the practice was safe, effective, responsive and well-led in all aspects of the service.

Not all staff had received training in safeguarding vulnerable adults in line with the practices identified mandatory training.

Patients were not protected against unsafe recruitment practices. Although there was a formal recruitment policy and procedure in place for the recruitment of staff, this had not been implemented. The practice manager confirmed that the recruitment process identified in the recruitment procedure had not been followed for those staff most recently recruited. Where the practice had deemed a disclosure and barring service (DBS) check (formally known as a criminal record bureau (CRB) check) to be unnecessary for the role and responsibilities of a particular staff member, a risk assessment identifying and minimising any risks had not been undertaken.

Non-medical staff at the practice were offered appropriate day-to-day support and leadership from the practice manager but improvements were needed in clinical leadership to ensure the practice was both responsive and effective in the delivery of treatment following the receipt of requested tests, such as blood tests and review of a patient following hospital discharge. The practice did not have a strategic approach to the management and planning of the service so there was no shared vision or planned development of the staff team.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Some aspects of the service were safe but improvements were needed.

Prescription changes and treatment recommendations in hospital discharge letters and patient test results had not been responded to by a GP in a timely manner.

Patients were not fully protected against the risks associated with the recruitment of staff.

There was no system in place or checking process to ensure any necessary action identified through patient safety alerts had been carried out.

Significant events records were disorganised and there was a lack of consistent recording of learning points and any follow up actions taken.

A cleaner was employed and the practice had produced cleaning schedules, but there was no monitoring process or formal audit undertaken to ensure cleaning was in line with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

A Control of Substances Hazardous to Health (COSHH) risk assessment was in place, but this had not been fully completed. The practice manager was unable to tell us if the cleaner responsible for handling COSHH items had received the appropriate training.

The practice had an up to date medicines management policy in place. Accurate medicines stock records were held by the practice nurse which included medicine expiry dates.

Training records demonstrated that all staff had received basic life support training and there was appropriate emergency equipment and medicines in place to enable staff to respond to a medical emergency.

The practice had appropriate safeguarding vulnerable adults and children's policies and procedures in place and staff were aware of how to report concerns.

Are services effective?

The non-medical administrative processes at the practice were mostly effective. However improvements were needed in clinical leadership to ensure the practice was both responsive and effective in the delivery of care or treatment.

Summary of findings

There was an effective referral process for any secondary care, but discharge letters and test results were not actioned by GPs in a timely manner.

The practice had not effectively monitored the service it provided, identified the changes needed or planned for future demands on the service.

The Practice had a system in place for completing clinical audit cycles. Although some clinical audits had been undertaken there was a lack of evidence to demonstrate that these had been used to inform practice and improve patient care.

The practice engaged appropriately with the local service and monthly multi-disciplinary meetings were held with other healthcare professionals.

The GPs kept their skills up to date through training undertaken as part of their appraisal and revalidation.

Are services caring?

The practice was caring. Patients comments were listened to and the practice responded appropriately to improve patient experience.

Patient feedback was mainly positive. Patients were happy with the care they received but felt the appointments system needed to be improved.

We observed staff treating patients with consideration and respect. Patients confirmed they were involved in making decisions about their care and their consent was sought prior to a physical examination or treatment.

Are services responsive to people's needs?

The practice was responsive to patients immediate needs but improvements were needed to ensure patients received the treatment they needed long term.

Administrative systems where in place to forward hospital discharge letters and patient test results to the GPs. However, these were not actioned in a timely manner.

There was an informative practice information leaflet available and the practice website offered a variety of information including links to other healthcare sources such as 111 and NHS choices. Patients could use the online service to book appointments, repeat prescriptions and request a text appointment reminder.

Home visits were arranged for those patients who were housebound, terminally ill or too ill to attend the practice.

Summary of findings

Staff told us that the GPs spoke several languages and had access to an interpreter and translation service via the NHS language line. The practice had a patient self-check-in touch screen which offered 16 language options.

Staff were familiar with and able to explain the complaints process. A complaints leaflet was available for patients this did not give full details of the procedure.

Are services well-led?

The principal GP and the practice manager formed the leadership of the practice. The clinical aspects of the practice were not well-led and improvements were needed.

The registered manager retired from full time practice in December 2013 and confirmed they were no longer in day to day control of the practice. The Care Quality Commission (CQC) had not been notified of this change and an application to cancel registration had not been received from the registered manager. The practice manager had taken on the role of registered manager but had not submitted an application for registration.

Practice meetings were held to promote learning and communication and non-clinical staff at the practice were offered appropriate day-to-day support and leadership from the practice manager.

Although areas of responsibility were known by staff, there were no clear monitoring or evaluation processes in place to demonstrate that appropriate actions had been followed through, leaving patients at potential risk of harm.

There was a named clinical lead but we found limited evidence of any clear or proactive leadership. The practice operated and staff responded to patient need on a day-to-day basis. There was limited evidence of any practice level clinical monitoring systems in place to identify, assess and manage risks relating to the health, welfare and safety of patients.

Clinical audits had been undertaken by the GP's, however there was little evidence to demonstrate how these were used to inform and improve practice.

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 had a caring and responsive approach to patients over the age of 75.

A safeguarding vulnerable adult's policy and procedure was in place and staff were aware of the reporting process.

Some staff had received vulnerable adults training in July 2014 and others were booked onto training in September 2014.

The practice offered health assessments for those patients over the age of 75 and home visits were provided for those patients housebound or too ill to attend the practice.

Staff liaised with district nurses and patients with complex needs were referred to "the Virtual Ward" operated through the Community Health Newham Directorate.

People with long-term conditions

The practice offered a caring and responsive service to those patients with a long term condition.

The practice operated weekly clinics to monitor and support those patients with long term conditions; these included asthma, diabetes, chronic obstructive pulmonary disease (COPD), osteoporosis, hypertension and epilepsy.

The practice liaised with district nurses to plan and manage the care of patients in their own homes and provide support for their carer. Although the practice did not offer any direct palliative care or end of life care they did engage appropriately with other local services. Practice meeting minutes evidenced some multidisciplinary working with community services such as hospitals, social workers, midwives, district and palliative care nurses.

GPs told us that they attended local learning network forums every three months which covered topics such as dementia and end of life care.

The practice had signed up to the local enhanced service (LES) for dementia, and dementia screening was undertaken as part of this.

Mothers, babies, children and young people

The practice provided a caring, effective and responsive service to mothers, babies, children and young people.

Summary of findings

The practice nurse provided weekly childhood immunisation clinics for new born babies, one year olds and pre-school children. Clinical staff liaised with health visitors regarding babies and young children.

A midwife and health visitor were attached to the practice to offer advice and support to pregnant women, their partners, mothers, children and new babies. The practice operated weekly ante-natal and postnatal clinics.

An appropriate safeguarding children's policy and procedure was in place and staff were able to adequately demonstrate what signs would indicate a child was at risk and how to report any concerns.

Some staff had undertaken safeguarding children training and others were due to attend the training in September 2014.

Clinicians recorded any child at risk using an electronic template. We were told that GPs submitted medical reports where requested for child protection case conferences.

The working-age population and those recently retired

The practice provided a caring and responsive service to working age people.

There were a variety of appointment options available to patients such as telephone consultations, Saturday appointments and extended hours for working people who found it difficult to access the practice during usual daytime hours.

Advice on smoking cessation was provided at the practice by the health care assistant. A well-woman clinic and advice sessions on sexual health and family planning were offered by the practice nurses.

The practice website informed patients that the health visitor who was attached to the practice, could provide help and information on family planning, healthy eating, getting the right exercise, emotional problems and relationship difficulties.

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

The practice provided a caring and responsive service to people in vulnerable circumstances who may have poor access to primary care.

The practice was signed up to the learning disability direct enhanced service (DES) to provide an annual health check for people with a learning disability to improve their health outcomes through the introduction of a health action plan.

Summary of findings

Staff told us that travellers, homeless people and sex workers could see a GP under a temporary registration, and anyone in need of an emergency appointment would always be seen.

People experiencing poor mental health

The practice provided a caring and responsive service to people experiencing poor mental health.

The practice was signed up to the mental health local enhanced service (LES) to provide a clinic for annual mental health checks. Staff told us that the practice undertook regular blood test monitoring for those patients identified as having a mental health condition.

Staff told us that a mental health link nurse attended the practice once a month and a cognitive behaviour therapy (CBT) service operated from the practice every Wednesday.

Clinical meeting minutes demonstrated that the practice discussed complicated mental health cases at multi-disciplinary and cluster meetings (a group of individual practices which meet on a monthly basis to share best practice and problem solve, to ensure local healthcare needs are highlighted to improve the delivery and provision of health services to patients).

Summary of findings

What people who use the service say

We received 43 written feedback cards as part of this inspection, spoke with six patients on the day of our visit and met with three members of the patient participation group (PPG)(a group of volunteer patients who form a link between the patients and the practice with a view to making a useful contribution to the improvement of existing services and help the practice to develop new services to identify and meet patients' needs). Most patients said they were happy with the service they received and felt staff were friendly, helpful, respectful and caring. All patients said they felt the GP's and nurses were knowledgeable and they felt they received safe care.

Although most patient feedback was positive about the care they received, most were unhappy with the waiting time for non-urgent appointments. We were told the wait was usually two to three weeks and on the day of our visit staff confirmed the first available non-urgent appointment was for 20 August. Patients also felt the layout of the reception area lacked privacy and most said they usually had to wait beyond their appointment time to be seen by the doctor. Some patients said it was difficult to get through on the telephone and by the time they got through all urgent appointments had been taken.

Members of the PPG we spoke with said any concerns they had raised with the practice had been responded to appropriately. We looked at the review of patient comments collected by the practice for 2012–2014. Patients said staff were friendly and helpful, the environment was clean but the lay out of the waiting area lacked privacy. Although patients said they were pleased with the care given by the GPs and nurses, they felt access to appointments and waiting times needed to be addressed. We saw the practice had taken positive steps to address the issues raised, including the installation of an additional telephone line, communication training for staff, a four week appointment booking system, the introduction of on-line appointment booking and telephone consultations.

Areas for improvement

Action the service MUST take to improve

- The practice must put systems in place to ensure patients are protected against the risks associated with unsafe recruitment of staff.
- The practice must ensure patients are protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the planning and delivery of such care or treatment.
- The practice must ensure patients are protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to identify, assess, monitor and manage risks relating to the health, welfare and safety of patients.
- The practice must give notice in writing to the Care Quality Commission (CQC) where a person other than the registered person carries on or manages the regulated activity and where a registered person ceases to manage the regulated activity.

Action the service SHOULD take to improve

- The practice should implement a system to ensure any necessary action identified from a patient safety alert has been carried out within an agreed timescale.
- The practice should implement a system to demonstrate how significant events are used to inform practice and improve patient care.
- The practice should ensure the cleaning of the practice is in line with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, through audits and monitoring.
- The practice should ensure the cleaner responsible for handling COSSH items has received the appropriate training and develop and implement a system to check that cleaning of the practice has been completed in accordance with the cleaning schedule.
- The practice should review their whistleblowing policy to ensure staff feel confident in raising concerns both internally and externally.

Summary of findings

- The practice should ensure that where staff act as a chaperone, they are aware of all aspects of the role.
- The practice should improve patient access to the complaints procedure as having to ask for this may discourage some patients from raisings a concern.
- The practice should ensure staff are aware of and working in line with the business plan to support the future development of the service.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

<Summary here>

Dr Altafuddin Ahmed

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included a second CQC inspector and a practice specialist. The GP and practice specialist were granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Dr Altafuddin Ahmed

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before.

Dr Altafuddin Ahmed is a single location practice which provides a primary medical service to approximately 5,400 patients in the Upton Park area of East London. The patient population groups served by the practice include a cross-section of socio-economic and ethnic groups. Staff said the majority of patients registered with the practice were from an Asian, Afro-Caribbean or East European background. The area is the second most deprived out of 326 local authorities in England. There is a transient patient population of approximately 30 patients joining and leaving the practice each month. A large number of patients are under 40 years of age.

The practice team was made up of one principal GP, five locum GPs, two practice nurses, a healthcare assistant, a practice and a deputy practice manager, a medical secretary, five receptionists and two summarisers.

Surgery opening hours are 8.00am – 7pm Monday to Friday (7.30am – 4.00pm Thursday). Extended hours operate between 6pm – 9pm Monday to Friday and 9am – 1pm Saturday.

GP appointments are available between 8.30am – 1pm and 2.30 – 6.30 Monday to Friday (8.00am – 12.30pm Thursday).

Dr Altafuddin Ahmed does not provide an out-of-hours service.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before.

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 06 August 2014 between 9am and 7pm

During our visit we spoke with a range of staff, including GPs, practice nurses, health care assistant, practice manager's, medical secretary and administration and receptionists.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

Some aspects of the service was safe but improvements were needed.

Prescription changes and treatment recommendations in hospital discharge letters and patient test results had not been responded to by a GP in a timely manner.

Patients were not fully protected against the risks associated with the recruitment of staff.

There was no system in place or checking process to ensure any necessary action identified through patient safety alerts had been carried out.

Significant events records were disorganised and there was a lack of consistent recording of learning points and any follow up actions taken.

A cleaner was employed and the practice had produced cleaning schedules, but there was no monitoring process or formal audit undertaken to ensure cleaning was in line with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

A Control of Substances Hazardous to Health (COSHH) risk assessment was in place, but this had not been fully completed. The practice manager was unable to tell us if the cleaner responsible for handling COSHH items had received the appropriate training.

The practice had an up to date medicines management policy in place. Accurate medicines stock records were held by the practice nurse which included medicine expiry dates.

Training records demonstrated that all staff had received basic life support training and there was appropriate emergency equipment and medicines in place to enable staff to respond to a medical emergency.

The practice had appropriate safeguarding vulnerable adults and children's policies and procedures in place and staff were aware of how to report concerns.

Safe track record

The practice had appropriate policies and procedures such as safeguarding adults and children, health and safety, infection control and dealing with significant events. All had recently been reviewed, were electronically stored and were accessible to all staff. Staff we spoke with demonstrated a clear understanding of how and to whom they should report any concerns. We spoke with six patients on the day of our inspection. All patients said they felt the GP and nurses were knowledgeable and they felt they received safe care.

The practice manager told us that they were responsible for forwarding all patient safety alerts to clinical staff who would then take the appropriate action. However, on looking into a recent safety alert dated 02 July 2014 from Newham clinical commissioning group (CCG) we found this had not been actioned by the practice on the day of our visit. The patient safety alert policy and procedure was clear and included timescales and responsibilities with learning through discussion in clinical meetings. The procedure stated that where the alert was found to be relevant to the practice, a list of patients affected would be produced and supplied to the GP by the practice manager. Although we were satisfied that patient safety alerts were usually made known to clinical staff and an appropriate policy and procedure was in place, there was no allocated person or checking process to ensure necessary action had been carried out within the agreed timescale.

Learning and improvement from safety incidents

Accident and incident management procedures were in place. All staff were aware of how to record and report accidents and incidents. There was an accident report book in place with one accident recorded for 2014. Appropriate action had been taken.

The Practice had a system in place for reporting, recording and monitoring significant events. Significant events were reviewed annually and staff said learning took place through regular discussion of these in clinical and practice meetings. We looked at the records for significant events. Records were disorganised and it was not always clear why an event had been categorised as a significant event. There was a lack of consistent recording of learning points and any follow up actions needed or taken by the practice. We spoke with GPs about learning and actions relating to significant events. Although they confirmed significant events were recorded and discussed in practice meetings, they were unable to assure us that there had been learning from these and the appropriate actions had taken place.

Are services safe?

Reliable safety systems and processes including safeguarding

Patients did not always receive timely treatment or care. Although administrative systems were in place to ensure GPs were given information regarding patient care and treatment in a timely manner, there was no robust checking system in place to identify when information had been reviewed and or actioned by the GP. There was evidence to demonstrate that discharge letters from hospitals regarding prescription changes and treatment recommendations and patient test results had not been responded to by a GP in a timely fashion. We were concerned to find one GP's email in box contained 175 test results which had not been actioned, 121 of these were abnormal. We also found a backlog of hospital discharge letters waiting to be processed. One hospital discharge letter dated 24 January 2014 had not been reviewed by the GP until 06 August 2014 and another dated 24 June 2014 had not been reviewed by the GP until 05 August 2014.

An appropriate safeguarding children's policy and procedure was in place. The principal GP had been allocated as the safeguarding lead for the practice. All staff spoken with were aware of who this person was, had an understanding of the indicators of abuse and how to report any concerns.

Clinical staff said they used an electronic template to record children at risk. Staff were aware of multi-agency working and we were told that GPs prepared reports for child protection case conferences where requested.

The safeguarding children policy stated that training was mandatory for all staff each year. GPs were required to have completed Level 3 training and all other clinical and non-clinical staff Level 2 or 1. Training records evidenced that some staff had completed training in July 2014 and others were booked to attend in September 2014.

A safeguarding vulnerable adult's policy and procedure was in place, which identified the practice manager as the safeguarding lead. Staff were aware of the reporting process and a flow chart was in place showing inter-agency reporting. Training records demonstrated that some staff had received training in July 2014 and others were booked onto training in September 2014.

Although the practice had a whistleblowing policy in place this appeared to discourage external reporting by stating 'we strongly encourage you to seek advice before reporting a concern to anyone external'. The policy informed staff that concerns needed to be reported to the practice manager or principal GP, who as husband and wife may present a conflict of interest. Not all staff we spoke with knew what action they could take should they have a concern with the management of the practice.

The practice had a chaperone policy and staff were aware that a patient could bring or request a chaperone. Information was available on the practice website and the patient self-check-in touch screen. We were told that reception staff, nurses and the healthcare assistant could act as a chaperone. The deputy practice manager told us that the reception staff had received chaperone training from themselves and the practice manager. The policy and training did not adequately cover the role of a chaperone. The policy did not include; the need for the chaperone to be DBS checked or the need for the examination or procedure to be witnessed and the training did not cover what a normal clinical examination should look like.

Monitoring safety and responding to risk

The practice had a building risk assessment in place, dated October 2013 which identified actions to reduce risks.

Non-clinical staff were provided with a lockable door, panic button, an alert button on staff computers which alerts other staff via their computers, and a barrier to deter and minimise any potential risks of physical violence. Staff told us that they occasionally worked alone. A lone working policy was in place and although staff had not received any formal training in lone working staff we spoke with understood how to ensure their own safety in the work place.

Maintenance records showed equipment had been serviced regularly and was in working order.

A Control of Substances Hazardous to Health (COSHH) risk assessment was in place, but this was undated and had not been fully completed. A list of cleaning items used at the practice had been recorded but information relating to the identification of risk and actions for minimising that risk had not been completed. The practice manager confirmed that all cleaning in the practice was undertaken by an external contract cleaner but was unable to confirm they had received appropriate COSHH training.

The practice had a fire safety policy for the protection of staff and patients. A fire risk assessment had been completed in October 2013 which included action points to

minimise risk. There was a designated fire marshal who confirmed they had received fire training and demonstrated sufficient knowledge and understanding of the practice procedure. Training records demonstrated that other staff had not received any fire safety training despite this being stated by the practice as mandatory training for all staff.

Medicines management

The practice had an up to date medicines management policy in place. Appropriate arrangements were in place to ensure the cold chain was maintained for the storage of immunisations and travel vaccines. The practice nurse showed us evidence that the fridge temperature had been checked on a daily basis to ensure it remained within acceptable limits (2-8 degrees Celsius) and that the vaccines were safe to use. The fridge was not hard wired (connected directly to a power supply to eliminate the need for a conventional plug) but there was a label next to the plug and socket connection reminding people not to switch the fridge off.

The practice nurse maintained medicine stock records and monitored medicine expiry dates. We checked these records which were accurate and all medicines checked were in date.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines. The medical secretary told us that they were responsible for repeat prescriptions but they were unaware if the practice had a repeat prescription policy.

Patients were able to visit in person or email the practice for repeat prescription requests.

Cleanliness and infection control

On the day of the inspection visit the practice was clean and hand cleansing gel was available for use throughout the practice.

The healthcare assistant was the allocated infection control lead for the practice. An annual infection control audit had been undertaken in June 2014. Areas identified as in need of improvement included the correct use of sharps bins and staff training in infection control training and Control of Substances Hazardous to Health (COSHH).

The practice infection control policy dated May 2013 stated that all staff should receive infection control refresher training at least annually. Training records demonstrated that all staff had received infection control training during June and July 2014.

The infection control policy did not include the cleaning of the premises beyond stating 'The practice clinical environment is clean and uncluttered'. There was no evidence that cleaning cloths had been identified to be used in particular areas to minimise cross contamination, such as not using the same cloth to clean the toilet as the consultation and treatment room. Mop buckets had not been emptied of water and mops heads were stored wet with no separation between them. It was not clear who was responsible for ensuring equipment was used and stored in line with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

The practice manager told us that a cleaner was employed but there was no formal contract in place and they did not know if the cleaner had received training in infection control. Cleaning schedules were in place, but the practice had no system to check whether the cleaning had been completed according to the schedule.

The infection control lead was also responsible for monitoring staff hand washing procedures. Records demonstrated that all staff had been monitored and marked as 'passed' during January 2014.

On the day of our visit clinical waste was correctly stored and a contract was seen to be in place for the collection and disposal of this. Sharps bins were available in clinical areas.

An up to date Legionella risk assessment was in place.

Staffing and recruitment

Although there was a formal recruitment policy and procedure in place for the recruitment of staff, this had not been implemented. We were told that the majority of both clinical and non-clinical staff had worked at the practice for a number of years. However, the practice manager confirmed that the recruitment process identified in the recruitment procedure had not been followed for those staff most recently recruited. One staff member employed short term in July 2014 to undertake summarising (the transferring of medical information from a patient's paper records to an electronic medical record) did not have all

Are services safe?

appropriate checks such as references and their right to work. Another staff member employed through an agency had no recruitment file and the practice was unable to demonstrate what if any pre-employment checks had been undertaken.

There was an induction process in place which included an introduction to the practice, employment terms and conditions, health and safety related policies and procedures and role specific training.

There were five locum doctors who worked on a regular basis in the practice. We looked at the locum doctor induction pack which offered a comprehensive introduction of the practice and the systems in operation.

The practice manager stated that a disclosure and barring service (DBS) check (formally known as a criminal record bureau (CRB) check) had not been obtained for all staff. Although this may not be relevant for some staff, a risk assessment had not been completed to demonstrate that this had been appropriately considered.

Dealing with Emergencies

The business continuity plan for the practice was dated 2012. This was in need of review as references to some of the staff and support structures were no longer relevant.

Training records demonstrated that staff had received basic life support training in January 2014.

Equipment

The practice had appropriate accessible emergency medicine and emergency equipment such as a defibrillator, nebuliser and oxygen cylinder to enable them to respond to a medical emergency. Not all staff we spoke with were aware of where the emergency equipment was held.

Are services effective?

(for example, treatment is effective)

Our findings

The non-medical administrative processes at the practice were mostly effective. However improvements were needed in clinical leadership to ensure the practice was both responsive and effective in the delivery of care or treatment.

There was an effective referral process for any secondary care, but discharge letters and test results were not actioned by GPs in a timely manner.

The practice had not effectively monitored the service it provided, identified the changes needed or planned for future demands on the service.

The Practice had a system in place for completing clinical audit cycles. Although some clinical audits had been undertaken there was a lack of evidence to demonstrate that these had been used to inform practice and improve patient care.

The practice engaged appropriately with the local service and monthly multi-disciplinary meetings were held with other healthcare professionals.

The GPs kept their skills up to date through training undertaken as part of their appraisal and revalidation.

Effective needs assessment, care & treatment in line with standards

Staff told us that clinical meetings took place monthly. Staff said they used clinical meetings to discuss the latest National Institute for Health and Care Excellence (NICE) guidance. Clinical meeting minutes evidenced the sharing of clinical guidance and best practice.

GPs told us that they attended weekly cluster meetings (groups of GPs from the local Clinical Commissioning Group (CCG) area) to share good practice and discuss local patient needs.

Clinical staff said that information from professional bodies such as patient safety alerts and changes to practice guidelines was passed to them by the practice manager. We looked at a safety alert dated 02 July 2014 and found this had not been actioned. We discussed this with the GP who was unable to demonstrate learning and appropriate actions from patient safety alerts took place in a time manner.

Monthly multi-disciplinary meetings were held with other healthcare professionals; these included mental health and community nurses.

Staff told us that consent was recorded on patient notes and any doubts about patient consent were discussed with a carer or parent.

Clinical staff we spoke with had a basic understanding of the Mental Capacity Act 2005.

Management, monitoring and improving outcomes for people

The principal GP told us that they did not offer palliative care to patients but they did meet with the community palliative care nurses every three months to identify and plan care and treatment for those patients with long term conditions.

The clinical meeting minutes evidenced that the GPs had introduced dementia assessments for those patients identified as at risk with memory concerns.

The practice nurse was responsible for the collation of data for the quality and outcomes framework (QOF). The QOF is a national group of indicators, against which a practice score points according to their level of achievement in the four domains of clinical, organisation, patient experience and additional services. High blood pressure is one of the most important preventable causes of premature ill health and death in the UK. The practice manager said the practice had purchased twelve blood pressure machines which had been distributed to at risk patients for self-monitoring.

There were no systems in place to monitor and improve quality beyond the local and national performance data from the Quality and Outcomes Framework (QOF). The GP's were unable to demonstrate that the practice used benchmarking (a measurement of the quality of policies, processes and systems, with a comparison with standard measurements, to determine what and where improvements can be made) to monitor and improve patient care.

We noted that the practice performance in the QOF reports for 2012 - 2013 showed a total of 94.3% of QOF points achieved which was 2.4% below the England average. However we noted that within the domains of organisation, patient experience and additional services the practice score was consistently above the England average.

Are services effective?

(for example, treatment is effective)

The Practice had a system in place for completing clinical audit cycles. GPs told us that clinical audits had been undertaken in the last six months for vitamin D in children, A&E attendance and Lipids. Although these clinical audits had been undertaken, the GPs were unable to demonstrate how these had resulted in an action plan for improvement of the practice or patient care necessary to complete the full audit cycle.

Effective Staffing, equipment and facilities

As well as the principal GP and five locum GPs, two part time nurses and a healthcare assistant were also employed at the practice. These staff told us that they felt supported in their role and confirmed that they met with the GPs each month to discuss clinical practice. Staff said that clinical advice could be sought from a GP as and when needed.

We saw evidence that the GPs kept their skills up to date through regular training. The GPs we spoke with said they were up to date with or were soon due for their revalidation.

Staff said they felt equipped to do their job and were supported in their role. Although non-clinical staff did not receive formal supervision they said they could access a manager for advice whenever they needed to.

The practice policies and procedures were clear and accessible to staff electronically.

We looked at eleven individual staff files which showed that staff had received an annual appraisal. Training had been identified as part of the appraisal system and we were shown the mandatory training matrix for each job role.

Working with other services

The practice engaged appropriately with other local services. Clinical and practice meeting minutes evidenced multidisciplinary working with community services such as hospitals, social workers, midwives, district and palliative care nurses.

Staff said a midwife held an ante-natal clinic at the practice once a week and a mental health link nurse attended the practice once a month. The district nurse made home visits to those patients unable to attend the practice for an annual flu vaccination and those in receipt of end of life care. Patients with complex needs were referred to "the Virtual Ward" operated through the Community Health Newham Directorate (district nursing teams) for assessment, and high risk patients were seen by the community matron.

We were told that patients in need of stoma care such as those with a colostomy, could receive an annual review at the practice as an alternative to attending a hospital.

Clinical meeting minutes demonstrated that the practice discussed complicated cases at multi-disciplinary and cluster meetings.

There was no effective system in place for the checking of and responding to patient test results. We were concerned to find over one hundred results awaiting action dating back to the 18 July 2014. The practice and deputy practice managers said they were responsible for forwarding test results to the GPs, but there was no follow-up system in place to ensure these had been seen by the GP and actioned.

Health, promotion and prevention

There was a range of information available to patients in the waiting areas which included leaflets which could be taken away from the practice.

The healthcare assistant said they were responsible for all new patient health checks which formed part of registration with the practice. Reception staff confirmed that a new patient registration always included a medical with the healthcare assistant before they could see a doctor. A patient information pack was available in English. Some information was available in alternative languages on the practice website.

The healthcare assistant was also responsible for phlebotomy (blood tests) and provided advice on smoking cessation.

Staff said they worked with district nurses, sharing information to ensure that those patients unable to attend the practice received appropriate services such as flu vaccinations.

The practice ran weekly chronic disease management clinics, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). The nurses said they kept up to date with good practice by attending annual training updates such as travel vaccinations, smear testing and child immunisation.

Are services effective?

(for example, treatment is effective)

The practice had signed up to a variety of LES (local enhanced services, schemes agreed by the CCG in response to local needs and priorities, sometimes adopting national service specifications) and DES (directed enhanced services, schemes that CCG's are required to establish or to offer contractors the opportunity to provide, linked to national priorities and agreements) such as pre-diabetes screening, latent tuberculosis, coronary heart disease, childhood immunisations and obesity management.

The clinical practice meeting minutes showed that the doctors attended local learning network forums every three months. These covered topics such as dementia, end of life care, smoking cessation and primary care emergencies.

The practice offered a weekly ante-natal clinic which was provided by the community midwife.

The practice recognised the role of carers and offered information on their website via a direct link to NHS choices.

We looked at the results of the National Patient Survey for 2013/14 which showed 73% of patients felt last nurse they saw or spoke to was good at listening to them (CCG (regional) average: 70%), 78% of patients had confidence and trust in the last nurse they saw or spoke to (CCG (regional) average: 77%) and 75% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG (regional) average: 77%). However the practice was shown as below the CCG (regional) average for the following sections: overall patient experience of the practice, making an appointment, and involvement in decisions about their care.

Are services caring?

Our findings

The practice was caring. Patient's comments were listened to and the practice responded appropriately to improve patient experience.

Patient feedback was mainly positive. Patients were happy with the care they received but felt the appointments system needed to be improved.

We observed staff treating patients with consideration and respect. Patients confirmed they were involved in making decisions about their care and their consent was sought prior to a physical examination or treatment.

Respect, dignity, compassion and empathy

We looked at the review of patient comments collected by the practice for 2012–2014. Patients had said staff were friendly and helpful, the environment was clean but the lay out of the waiting area lacked privacy. Although patients had said they were pleased with the care given by the GPs and nurses, they felt access to appointments and waiting times needed to be addressed. We saw the practice had taken positive steps to address the issues raised, including the installation of an additional telephone line, communication training for staff, a four week appointment booking system, the introduction of on-line appointment booking and telephone consultations.

The practice did not offer any direct support with bereavement. The practice website offered practical information following a death, such as contacting the funeral director and the issue of a death certificate. In addition a cognitive behaviour therapy (CBT) service operated from the practice on a Wednesday which bereaved people could access. GPs could also refer patients to the community counselling team.

We heard staff speak to patients in a considerate and respectful manner. We noted that the reception and patient waiting area offered limited privacy. However, the practice had introduced a patient self-check-in touch screen which offered a more discreet check-in service and limited patient queues. We were informed that the patient self-check-in screen offered 16 language options and information on the practice website was available in a number of different languages.

Involvement in decisions and consent

Staff said patients came from a variety of backgrounds, a large number being Asian, Afro Caribbean and Eastern European. We were told that the staff team spoke a variety of languages and where needed the NHS language line was used.

Patients told us that they were given sufficient information by the doctor or nurse in an accessible format regarding their condition and were involved in making a choice about their treatment options. Some patients said the GP gave them printed information from the internet regarding their condition and/or treatment.

The National Patient Survey for 2012/13 showed 56% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG (regional) average of 70%.

A consent policy was in place. The chaperone policy also included a statement that consent must be sought and recorded before an examination. GP's we spoke with said it was their practice to request and record informed consent and patients confirmed that clinical staff requested their consent before undertaking a physical examination or giving treatment.

Patients had access to one female locum GP on a Thursday Morning.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive to patient's immediate needs but improvements were needed to ensure patients received the treatment they needed long term.

Administrative systems where in place to forward hospital discharge letters and patient test results to the GPs. However, these were not actioned in a timely manner.

There was an informative practice information leaflet available and the practice website offered a variety of information including links to other healthcare sources such as 111 and NHS choices. Patients could use the online service to book appointments, repeat prescriptions and request a text appointment reminder.

Home visits were arranged for those patients who were housebound, terminally ill or too ill to attend the practice.

Staff told us that the GPs spoke several languages and had access to an interpreter and translation service via the NHS language line. The practice had a patient self-check-in touch screen which offered 16 language options.

Staff were familiar with and able to explain the complaints process. A complaints leaflet was available for patients this did not give full details of the procedure.

Responding to and meeting people's needs

Staff told us that the majority of patients were from an Asian, Afro-Caribbean or Eastern European background. We were told that the GPs spoke several languages and staff had access to an interpreter and translation service via NHS language line. On the day of the inspection visit we were told by one patient that they were waiting for an interpreter to arrive to support them with their appointment with the nurse.

Although we were told that a number of languages were spoken amongst the staff team, there was no written practice information available in an alternative language to English other than that provided nationally by the NHS. The patient self-check-in touch screen did however offer 16 language options and information on the practice website was available in a number of different languages.

We spoke with staff about vulnerable patient groups and what measures the practice had taken to engage with these groups and ensure that services were accessible. We were told that the practice was signed up to the learning disability directed enhanced service (DES) to provide an annual health check for people with a learning disability to improve their health outcomes through the introduction of a health action plan. Staff told us that the GPs would always make time to see a patient who was known to have a long term condition such as cancer.

We saw evidence that the practice had responded to patient feedback through the introduction of telephone consultations, an additional telephone line, a Saturday clinic, online appointment booking and repeat prescription ordering.

Access to the service

All patient areas were accessible to all patients. There was lift access to the first floor for those patients with mobility difficulties.

The practice information leaflet informed patients that appointments could be booked up to four weeks in advance. Staff said patients could telephone, call in person or use the online service to book an appointment. Although appointments could be booked up to four weeks in advance we were told that non urgent appointments were usually fully booked for the first two weeks. Patients said this meant they had to wait at least two weeks for the first available appointment which they felt was too long.

Patients could also request repeat prescriptions on line and request to receive a text reminder of their appointment.

Home visits were arranged for those patients who were housebound, terminally ill or too ill to attend the practice. We saw that this information was contained in the practice information leaflet.

Discussions with patients and staff demonstrated that the doctors promoted a caring approach with a focus on responding to patient need on a daily basis. Appointment choices consisted of urgent, general, telephone consultation and home visits. Extended hours operated between 6.00pm – 9.00pm Monday – Friday and 9.00am – 1.00pm Saturday for working people who found it difficult to access the practice during usual daytime hours.

We received 43 patient feedback cards as part of this inspection. In general patients were satisfied with service they received and felt staff were friendly and doctors and nurses were caring. Patients felt the appointments system could be improved and some patients were unhappy that

Are services responsive to people's needs?

(for example, to feedback?)

they had to wait two to three weeks for a non-urgent appointment. we were told that telephone lines were often very busy and the appointments system involved an early morning queue to secure an urgent appointment. Most patients said staff were respectful and caring and reception staff were helpful and friendly. Some patients suggested communication could be improved and felt the language barrier between staff and patients sometimes caused misunderstandings that could otherwise be avoided.

Patients were mostly positive about the care they received but were unhappy that they had to wait two to three weeks for a non-urgent appointment.

Meeting people's needs

There was evidence to demonstrate that discharge letters from hospitals regarding prescription changes and treatment recommendations had not been responded to by GPs in a timely fashion. For example one letter dated 24 January 2014 had not been reviewed by a GP until 06 August 2014 and another dated 24 June 2014 had not been reviewed by a GP until 05 August 2014. In addition to these delays there was there was no clear system in place to evidence that recommendations in these letters had been actioned.

We also found that the system in place for GPs to respond to a patient's test result was inadequate. We found one GP's email in box contained 175 test results which had not been actioned, 121 of these were abnormal. There was no effective system in place to identify which results had been actioned and no checking system to ensure these actions were timely.

A lift was installed to enable those patients with mobility difficulties to access the whole building.

Staff told us that they were improving patient access through the online service to book appointments and make repeat prescription requests.

There were a variety of appointment options available to patients such as telephone consultations, home visits, Saturday appointments and extended hours for working people who found it difficult to access the practice during usual daytime hours.

Patients said they usually had to wait beyond their appointment time to be seen by the doctor. Patients also said it was difficult to get an urgent appointment and the waiting time for non-urgent appointments was two to three weeks. On the day of our inspection staff confirmed the first available non-urgent appointment was for 20th August.

Staff said new patients were given a practice leaflet which detailed the services available at the practice. Information was also available via the practice website. However, these two sources of information were not always consistent, for example the patient information leaflet showed a CBT (cognitive behavioural therapy) clinic on a Wednesday however this information was missing from the website.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

Staff were familiar with and able to explain the complaints process. There was a complaints and suggestions poster on display in the waiting area informing patients of their right to raise a concern. There was also a comments and suggestions box next to the main reception office.

Although a complaints leaflet was available for patients this did not give details full details of the procedure. The leaflet did not inform patients of the timescales for the acknowledgement, investigation and outcome of their complaint. Staff said patients could ask for a copy of the full complaints procedure which was held behind reception. However, having to ask for this may discourage some patients from raising their concern.

Staff said all complaints were passed to the practice manager. or the principal GP in their absence.

The complaints procedure stated that acknowledgement of a complaint would be made in writing within three working days and resolved within six months. We looked at the complaints records. There were four complaints recorded for 2014, all of which had been investigated and responded to within the agreed timescale.

The practice manager told us that they completed an annual review of complaints received for learning and monitoring purposes which was then shared with senior management.

The practice had set up a Patient Participation Group (PPG)(a group of volunteer patients who form a link

Are services responsive to people's needs?

(for example, to feedback?)

between the patients and the practice with a view to making a useful contribution to the improvement of existing services and help the practice to develop new services to identify and meet patients' needs). PPG members we spoke with said any concerns raised by them had been responded to appropriately. For example, problems with getting appointments had been addressed with the introduction of a third telephone line and an on-line booking service.

Are services well-led?

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

Our findings

The principal GP and the practice manager formed the leadership of the practice. The clinical aspects of the practice were not well-led and improvements were needed.

The registered manager retired from full time practice in December 2013 and confirmed they were no longer in day to day control of the practice. The Care Quality Commission (CQC) had not been notified of this change and an application to cancel registration had not been received from the registered manager. The practice manager had taken on the role of registered manager but had not submitted an application for registration.

Practice meetings were held to promote learning and communication and non-clinical staff at the practice were offered appropriate day-to-day support and leadership from the practice manager.

Although areas of responsibility were known by staff, there were no clear monitoring or evaluation processes in place to demonstrate that appropriate actions had been followed through, leaving patients at potential risk of harm.

There was a named clinical lead but we found limited evidence of any clear or proactive leadership. The practice operated and staff responded to patient need on a day-to-day basis. There was limited evidence of any practice level clinical monitoring systems in place to identify, assess and manage risks relating to the health, welfare and safety of patients.

Clinical audits had been undertaken by the GP's, however there was little evidence to demonstrate how these were used to inform and improve practice.

Leadership & Culture

The principal GP and the practice manager formed the leadership within the practice. The practice manager said the culture of the practice was one of openness and transparency.

The principal GP was nearing retirement, but there was no succession plan in place for the future of the practice. We were shown a five year business development plan, but this did not address the implications of the principal GP retiring and when asked staff were unable to tell us the future plans of the practice.

Staff had little understanding of the vision and values of the practice beyond the immediate care of patients and treating people with dignity and respect. Some staff were aware of the practice's participation in the 'First 4 Health Federation' (a group of practice GPs, Managers and Clinicians across the London Borough of Newham that have agreed a common management structure and are working towards adopting standard clinical practices and joint clinical services).

The registered manager retired from full time practice in December 2013. However, they continued to work three sessions a week at the practice as a locum GP. The registered manager told us that they were no longer in day to day control of the practice and undertook no managerial responsibilities. The Care Quality Commission (CQC) had not been notified of this change and an application to cancel registration had not been received from the registered manager. The practice manager stated that they had undertaken the role of registered manager and they intended to submit an application for registration.

Governance Arrangements

The practice had not effectively monitored the service it provided, identified the changes needed or planned for future demands on the service. Although appropriate policies and procedures were in place these were not always followed. For example recruitment of staff and the review and follow-up of a patient test result or hospital discharge letter.

Although we saw evidence of regular meetings to discuss practice issues, insufficient time was devoted to the leadership of the practice. Through discussions with staff and review of records it was evident that the principal GP devoted little time to the development of the service which was a shortfall in leadership.

Policies and procedures identified lines of responsibility. Staff were aware of who to report to and their line of accountability. Although there were some monitoring processes in place these mainly related to the non-medical aspects of the practice. The practice was unable to evidence how the clinical aspects of the practice were monitored and evaluated. For example, patient safety alerts were passed to clinical staff by the practice manager but there was no follow-up action to confirm these had been implemented or actioned and how any learning from these had improved patient care.

Are services well-led?

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

The business development plan identified and addressed areas requiring development but there was no evidence that staff at the practice were aware of what these were and how they were working towards these.

Systems to monitor and improve quality & improvement (leadership)

The GPs had undertaken clinical audits. The principal GP told us that a recent clinical audit which they had used as part of their revalidation had also improved patient care. This related to deficiency of vitamin D amongst children. The GP was, however, unable to explain how these clinical audits had resulted in an improved service for patients.

We saw some evidence of repeat prescribing audits (for anti-psychotics) which had been undertaken by the CCG, but there was no evidence that the practice had a system in place to monitor and improve quality beyond the local and national performance data from the Quality and Outcomes Framework (QOF). There was no other evidence available to demonstrate that the practice used benchmarking (a measurement of the quality of policies, processes and systems, with a comparison with standard measurements, to determine what and where improvements can be made) to monitor and improve patient care.

Patient experience and involvement

The practice listened to patient comments and responded appropriately which resulted in a better patient experience. The practice had undertaken patient feedback via 'Patient Satisfaction Questionnaires'. We looked at the summary of results for the year 2013 to 2014. Most patients found staff to be friendly and helpful, though not everyone felt staff were always polite. They also felt the environment was clean and they were pleased with the care they received from the doctors and nurses. Areas where patients felt improvements could be made were access to appointments, waiting times and the layout of waiting area which they felt lacked privacy. The practice had responded positively and had taken action to address these issues. A new telephone line had been installed and an on line appointment booking system had been made available. Staff had received communication training and a four week appointment booking system had been introduced. In addition the practice had introduced a telephone consultation service.

There was a 'Patient Participation Group' (PPG)(a group of volunteer patients who form a link between the patients and the practice with a view to making a useful contribution to the improvement of existing services and help the practice to develop new services to identify and meet patients' needs), which had been running since November 2011.

PPG meetings took place every three months. Minutes from the PPG meeting evidenced changes which had been made to the operation of the practice following patient feedback, such as the introduction of an additional telephone line, a review of the repeat prescription process and the introduction of a suggestion box.

We met with three members of the PPG. They told us that the practice listened when they raised concerns or suggested areas for improvement such as communication, access to language line, prescription management, the appointments system and disabled access to the building.

Staff we spoke with were aware of the practice Patient Participation Group (PPG) and its function. Some staff attended this group and one said they were given feedback in practice meetings and they were hoping to attend these meetings in the future.

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

Most staff said they felt supported in their role but role specific tasks were not always reallocated when vacancies arose or staff went on annual leave. Staff said they sometimes came back to an accumulation of work which was demoralising and potentially unsafe for patients. For example, non-urgent referrals and patient test results had not been actioned in a timely manner when staff took annual leave.

All staff had received an annual appraisal which identified their training needs in line with the responsibilities of their job.

Management lead through learning & improvement

Practice meetings were held each month to discuss issues and address any concerns. We looked at the minutes for those meetings which took place in 2014. Minutes identified what the learning had been, who had been responsible and any action points. We saw that these were followed thorough at the next meeting. Learning covered topics such as infection control, health screening, immunisations, QOF targets, complaints and patient feedback. However there was insufficient evidence to demonstrate that the practice responded to patient safety

Are services well-led?

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

alerts and significant events in a timely manner. There was also a lack of consistent recording and follow up actions needed or taken by the practice. GPs stated that significant events were recorded and discussed in practice meetings but they were unable to demonstrate that there had been learning from these and the appropriate actions had taken place.

Clinical meeting minutes evidenced that they were attended by most staff on a regular basis. Action points were recorded and followed through at the next meeting.

Identification & Management of Risk

We were concerned to find over one hundred patient test results awaiting action by a GP. We were also concerned to find that advice and treatment instructions in some hospital discharge letters had not been actioned by GPs in a timely fashion.

Staff said there was no policy in place regarding managing changes in demand and there was no evidence that the practice had considered or planned how it would meet the needs of the patient's long term.

Older people

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

Our findings

The practice had a caring and responsive approach to patients over the age of 75.

A safeguarding vulnerable adult's policy and procedure was in place, which identified the practice manager as the safeguarding lead. Staff were aware of the reporting process and a flow chart was in place showing inter-agency reporting. Training records demonstrated that some staff had received training in July 2014 and others were booked onto training in September 2014.

The practice offered health assessments for those patients over the age of 75. The principal GP undertook home visits for those patients housebound or too ill to attend the practice. Staff said they liaised with district nurses to ensure that those patients unable to attend the practice had access to appropriate services such as end of life care and annual flu vaccinations. Patients with complex needs were referred to "the Virtual Ward" operated through the Community Health Newham Directorate for assessment, and high risk patients were seen by the community matron.

The staff at the practice said all patients over the age of 75 were allocated a named GP in line with contractual requirements and any unplanned hospital admissions were subject to review.

The practice was also aware that some pharmacies provided a dosset box service to those patients who required additional support in the management of their own medicines.

People with long term conditions

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

Our findings

The practice offered a caring and responsive service to those patients with a long term condition.

The practice operated weekly clinics to monitor and support those patients with long term conditions, these included asthma, diabetes, chronic obstructive pulmonary disease (COPD), osteoporosis, hypertension and epilepsy.

The practice had signed up to a variety of LES (local enhanced services) and DES (directed enhanced services) such as pre-diabetes screening, latent tuberculosis, coronary heart disease and obesity management.

The practice liaised with district nurses to plan and manage the care of patients in their own homes and provide support for their carer. Annual health checks were undertaken for those patients in receipt of stoma care and those with a mental health condition. Patients with complex needs were referred to "the Virtual Ward" operated through the Community Health Newham Directorate for assessment and high risk patients were seen by the community matron.

The practice had signed up to the local enhanced service (LES) for dementia, and dementia screening was undertaken as part of this.

Although the practice did not offer any direct palliative care or end of life care they did engage appropriately with other local services. Clinical and practice meeting minutes evidenced some multidisciplinary working with community services such as hospitals, social workers, midwives, district and palliative care nurses.

GPs said they attended local learning network forums every three month which covered topics such as dementia and end of life care.

Mothers, babies, children and young people

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

Our findings

The practice provided a caring, effective and responsive service to mothers, babies, children and young people.

The 2013 Government statistics for Births in England recorded Newham as having the highest birth-rate in London. A midwife was attached to the practice to offer support to pregnant women, their partners and new babies before, during and after birth. As well as monitoring the health of the mother and baby, they also ran weekly antenatal and parenting classes, explained options on the delivery of the baby and gave advice on breast feeding.

The practice nurse provided weekly childhood immunisation clinics for new born babies, one year olds and pre-school children and clinical staff liaised with health visitors regarding babies and young children. Staff said ante-natal and postnatal clinics were held at the practice each week by a midwife.

The practice had a health visitor attached to the practice who offered advice and support to mothers with children under five, advising on hygiene, safety, feeding and sleeping.

An appropriate safeguarding children's policy and procedure was in place and staff were aware of their safeguarding lead. Staff were able to adequately demonstrate what signs would indicate a child was at risk and how to report any concerns. Some staff had undertaken safeguarding children training and others were due to attend the training in September 2014.

Clinicians recorded any child at risk using an electronic template. We were told that GPs submitted medical reports where requested for child protection case conferences.

Patients over the age of 15 were offered health checks by their GP.

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 a caring, effective and responsive service to working age people.

The practice website offered patients general information about the services provided by the practice with links to the NHS website.

There were a variety of appointment options available to patients such as telephone consultations, Saturday appointments and extended hours for working people who found it difficult to access the practice during usual daytime hours.

Advice on smoking cessation was provided at the practice by the health care assistant. Sexual health information, chlamydia testing and family planning services were offered by the practice nurses.

The practice website informed patients that the health visitor who was attached to the practice, could provide help and information on family planning, healthy eating, getting the right exercise, emotional problems and relationship difficulties.

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

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

Our findings

The practice provided a caring and responsive service to people in vulnerable circumstances who may have poor access to primary care.

The practice was signed up to the learning disability direct enhanced service (DES) to provide an annual health check for people with a learning disability to improve their health outcomes through the introduction of a health action plan. We were told that staff were booked onto learning disability awareness training in on 21st August 2014.

In March 2012 statistics, Newham was recorded as having a rate of 19.24% per 1000 households in temporary accommodation compared to a London average of 11.05%. Staff told us that travellers, homeless people and sex workers could see a GP under a temporary registration, and anyone in need of an emergency appointment would always be seen.

People experiencing poor mental health

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

Our findings

The practice provided a caring, effective and responsive service to people experiencing poor mental health.

The practice was signed up to the mental health local enhanced service (LES) to provide a clinic for annual mental health checks. Staff told us that the practice undertook regular blood test monitoring for those patients identified as having a mental health condition.

Staff said a mental health link nurse attended the practice once a month and a cognitive behaviour therapy (CBT) service operated from the practice every Wednesday.

Clinical meeting minutes demonstrated that the practice discussed complicated mental health cases at multi-disciplinary and cluster meetings (a group of individual practices which meet on a monthly basis to share best practice and problem solve, to ensure local healthcare needs are highlighted to improve the delivery and provision of health services to patients).

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of patients. Patients were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1)(b)(i)(ii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. Patients were not protected against the risks associated with unsafe recruitment of staff. Regulation 21 (a)(i) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. Patients were not protected against the risk of inappropriate or unsafe care. Regulation 10 (1)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 Health & Social Care Act 2008 (Registration) Regulations 2009 Notice of changes. The provider failed to give notice in writing to the Commission of notifiable events. Regulation 15 (1)(a)(b)).