# DMC Healthcare 1

## Quality Report

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

## Contents

# Summary of findings

## Overall summary

DMC Healthcare 1 provides primary medical care and a range of services including hypertension, diabetes, and child health and baby immunisations clinics to 1,300 people in the Stratford area of east London. It is open 9am to 6.30pm on Monday to Friday with the exception of Tuesday when the practice is open until 7.30pm. Outside of these times, an out of hour's service is available run by Newham GP Cooperative.

The main concerns identified prior to the inspection were that there was a lower than average number of medication reviews for patients on repeat medicines and a national GP survey carried out by an independent organisation in 2013 noted that the practice was among the worst for being able to get through to the surgery by telephone. A positive aspect was that GPs were better than average at explaining tests and treatments to patients.

We carried out an announced inspection on 4 August 2014. The inspection took place over one day and the inspection team comprised a CQC Lead Inspector, GP specialist advisor, CQC inspector, practice management specialist, and Expert by Experience. Before the inspection we talked to Newham Clinical Commissioning Group (CCG) and three health professionals in the community who dealt with patients from the practice. We talked to three patients who belonged to the Patient Participation Group (PPG) at the practice. We reviewed information from patient surveys of the practice.

On the day of the inspection we observed staff talking to patients and spoke to three patients in the waiting area. We spoke to the practice manager, two GPs including the clinical lead, pharmacist, health care assistant and three reception/administration staff. We reviewed practice management and staff files, and 21 comment cards which patients had posted on the reception desk.

The practice shared equipment and staff with another GP practice situated within Vicarage Lane Health Centre. Some facilities were shared with other health services within the premises.

The provider was in breach of regulations related to:

- assessing and monitoring the quality of service provision
- management of medicines
- supporting workers

Care was planned and delivered effectively and patients underwent regular monitoring and medicines reviews when necessary. Clinical audits were carried out and information resulting from them used to improve patient outcomes. Staff worked with multidisciplinary teams to coordinate care for patients.

Patients were positive about their care and treatment and felt they were treated with dignity and respect by staff. They also felt staff involved them in their own care and explained things to them. However, the telephone system had been a problem for over five years and meant patients could not reasonably contact the practice by telephone. Patients often had to attend the surgery in person to make an appointment. Although staff had tried to resolve this issue with senior management there was no action plan, with timescales in place, to improve the situation.

Governance arrangements were clear and staff knew who was the responsible lead for each area. Most staff felt supported and able to develop although some staff felt undervalued. Not all staff had received training in safeguarding and basic life support.

We found the practice had safe systems in place for reporting and recording incidents. Staff understood their role and the processes for reporting incidents that affected patient's safety. Learning and improvement had resulted from significant incidents. However, the emergency kit contained adrenaline which was out of date.

### Older People

The practice responded to the needs of older patients and those over the age of 75 had a named GP. Doctors worked with other healthcare professionals to coordinate care plans for older patients at risk of emergency hospital admissions.

### People with long-term conditions

The practice supported patients with long term conditions. Dedicated clinics and annual reviews were available for patients with long term conditions.

# Summary of findings

### Mothers, babies, children and young people

Regular child health surveillance clinics and maternity services were offered to this group of patients. Young patients under the age of 16 years were offered health checks.

### The working-age population and those recently retired

The practice responded to the needs of working people by offering and appointments from 9am to 6.30pm on Mondays to Fridays with extended hours on a Tuesday evening until 7.30pm.

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

There were no barriers to accessing care for this group of patients. Clinical staff worked closely with other community services to support patients who misused drugs and alcohol.

### People experiencing poor mental health

Doctors coordinated care of this group of patients with the Mental Health Community team which was located in the building. Patients with poor mental health had annual reviews and health checks.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) 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?**

We found the practice had safe systems in place for reporting and recording incidents. Staff understood their role and the processes for reporting incidents that affected patient's safety. Learning and improvement from significant incidents was shared with staff. Whilst there were policies and procedures for safeguarding some staff had not received training in the safeguarding of children and vulnerable adults.

Patients underwent regular monitoring and medicines reviews when necessary. However the storage of medicines was inadequate. We found vaccination medicine which was past its expiry date and emergency medicines and syringes which were out of date. Staff were able to tell us how they would react in the event of an emergency. We checked staff records and found that four staff including a nurse were overdue by at least six months to have their training updates in basic life support.

The practice was clean and had some infection control measures in place to ensure patients were not at risk of cross contamination from healthcare associated infections.

**Are services effective?**

Care was planned and delivered effectively in line with current legislation and nationally recognised evidence-based practice. Regular clinical and medicines management review meetings were held within the practice where they discussed guidance updates, audits, significant events and care pathways. Clinical audits were carried out and information resulting from them used to improve patient outcomes. There was a system in place for completing clinical audit cycles.

Clinical staff engaged and liaised with other health and social care services such as the Community Mental Health Team. They attended multidisciplinary meetings and shared careplans to facilitate coordinated care for patients and prevent admissions to hospital. The practice had systems in place for managing blood and other test results.

Health promotion and preventative clinics were regularly held. All over 75 year olds and under 16 year olds who had not attended the practice recently, were offered health checks. Patients were offered vascular risk assessments so that preventative measures could be taken for those found to be at high risk of developing cardiovascular disease (CVD).

# Summary of findings

Appropriate checks were undertaken before staff started to work at the practice to ensure they were qualified and competent. All staff told us they received an annual appraisal although there were no formal supervision meetings. Staff were trained in areas commensurate with their job roles however some staff were not up to date with mandatory training such as vulnerable adults safeguarding and basic life support.

**Are services caring?**

Patients were treated with dignity and respect. Patients told us and we observed staff in the reception area speaking to patients respectfully and sympathetically. Bereaved relatives were sent sympathy cards. There was no information on display or in leaflets to advise patients they could speak to staff confidentially although staff told us they took patients to a side room if they wanted privacy to talk. There was a chaperone policy and reception staff had received specific training in chaperoning which was always offered to patients.

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

Telephone access to the practice for patients was poor. Patient surveys and patients we spoke with during our inspection indicated that it was very difficult for them to get through to the practice to make an appointment by telephone. This had been a problem for over five years and been raised with the provider on several occasions. Staff told us that discussions were ongoing with the owners of the building and NHS England but there was no action plan in place with agreed timescales, to resolve this matter.

Regular diabetes and asthma clinics were held and vascular health checks were offered. Older patients and those who were housebound were identified on the patient database and telephoned every month, if they had not been to the practice recently, to ask if they had any needs regarding their healthcare.

The complaints system was effective and had resulted in service improvements as a result of complaints made, although there was conflicting information for patients on the complaints procedure in the practice leaflet and website.

**Are services well-led?**

There were regular governance meetings where the issue of the poor telephone system was brought to the attention of the partner GPs, who were the senior management, because it generated a great deal of patient dissatisfaction. However, despite these meetings the staff within the practice felt little had been done over five years to improve the situation.

# Summary of findings

Some improvements had been made so that there were more available urgent appointments for patients. There was an active Patient Participation Group and regular patient surveys. Concerns about staff/patient security had been addressed and improved security had resulted in the waiting and consultation rooms.

Staff were able to tell us of similar general aims which were to provide good patient care and improve it, although the practice did not have a formal mission statement or set of organisational objectives. Governance arrangements were clear and staff knew who was the responsible lead for each area. Most staff felt supported and able to develop although some staff felt undervalued.

The practice monitored the Quality and Outcomes Framework (QOF) and local benchmarking data to identify areas for improvement. Practice performance was reviewed and discussed at clinical governance meetings and lessons shared internally through minuted meetings and externally through the Clinical Commissioning Group (CCG) peer review meetings.

# 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 responded to the needs of older people. All patients over the age of 75 years had a named GP. We saw evidence that the practice worked with multidisciplinary teams to discuss strategies and care plans for older patients at risk of emergency hospital admissions. Older people who had not been in contact with the surgery recently were contacted to ask how the practice could help with their health needs. Home visits were offered to those who were housebound or too ill to attend the surgery.

Although there was a vulnerable adults' policy and procedure in place, not all staff had received training in this area.

**People with long-term conditions**

The practice supported patients with long term conditions. Dedicated clinics were available for patients with hypertension, asthma and diabetes. All patients with heart disease received an annual review and were offered a referral to health trainers for healthy lifestyle advice.

GPs used a risk tool for patients with long term conditions such as diabetes. Multidisciplinary team meetings with other community healthcare professionals were held throughout the year and doctors shared careplans to facilitate coordinated care for patients and prevent admissions to hospital.

**Mothers, babies, children and young people**

Child health surveillance clinics were held to monitor child development and administer vaccination and immunisations for new born babies, one year olds and pre-school children.

The child safeguarding lead attended safeguarding meetings with multidisciplinary teams to share information and improve the safety of vulnerable children. They used the practice database to highlight vulnerable children and their families so that all staff would have access to up to date information.

The practice had a teenager confidentiality policy and staff and recorded when they had assessed a patient under the terms of the Gillick competency. Under 16 year olds, who had not been into the practice recently, were regularly contacted to offer them a health check.

# Summary of findings

**The working-age population and those recently retired**

The practice responded to the needs of working people by offering appointments from 9am to 6.30pm Monday to Friday with the exception of Tuesday night when the practice had appointments until 7.30pm. Patients found appointment times convenient. Patients could email the practice, but there was no online appointment booking. Repeat prescription requests were available for those patients who found it difficult to access the practice by telephone or in person.

Patients were offered vascular risk assessments so that preventative measures could be taken for those found to be at high risk of developing cardiovascular disease (CVD).

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

There were no barriers to accessing the practice for patients such as those who were homeless or who did not have the correct information such as ID/proof of address in order to register as patients with the practice.

The pharmacist and GPs at the practice worked closely with the Newham Drug and Alcohol Service to support vulnerable patients such as those who misused drugs and alcohol.

Carers for vulnerable patients were registered on the database so that all staff had access to that information when a patient attended the practice. Staff were aware of the principles of the Mental Capacity Act 2005 and understood they needed to obtain patient consent.

Although there was a vulnerable adults policy and procedure in place not all staff had received training in the safeguarding of vulnerable adults.

**People experiencing poor mental health**

The practice responded to the needs of patients experiencing poor mental health. They had employed a pharmacist to help carrying out depression assessments on patients.

The GPs worked closely with the Mental Health Community team which was located in the building. Patients with poor mental health had annual reviews and health checks. Doctors monitored those patients who took lithium.

# Summary of findings

## What people who use the service say

We spoke to six patients as part of the inspection including three members of the Patient Participation Group (PPG) and they were complimentary about the staff and said they were treated with respect and confidentiality. They told us they received good care and treatment and the doctors, nurses and pharmacist took time to explain things to them. 21 patients completed comment cards which were left in the reception area and comments were overwhelmingly positive about the care and treatment they received at the practice.

Before our visit we reviewed the results of an independent national GP survey of the practice carried out in 2013 which was rated "among the worst" because over 60% of patients found it difficult to make an appointment by telephone. We found the situation was the same with the patients we spoke to and those who completed comment cards. Patients who did not find it difficult to make an appointment told us they came into the practice to make one as they could not get through on the telephone. Patients were happy with the appointment times and their care and treatment.

## Areas for improvement

**Action the service MUST take to improve**

- The practice must improve the telephone system to enable patients to contact the practice within a reasonable time.
- All medicines must be stored safely and there should be a system to ensure medicines are not stored past their expiry dates.
- The staff training matrix was not updated and did not contain all staff members so that training needs and updates were not easily identified and arranged for staff. The practice must ensure that all staff receive appropriate training in safeguarding and basic life support.

Note: detailed actions will be written in detailed findings section of the report.

**Action the service SHOULD take to improve**

- Information regarding the complaints procedure should be the same on the website and in the practice leaflet.
- There was no overall vision and organisation strategy for the practice that identified key priorities and objectives.

# DMC Healthcare 1

**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 CQC inspector, practice management specialist, and Expert by Experience.

## Background to DMC Healthcare 1

DMC Healthcare group runs GP practices and walk-in centres in London and the south east of England. DMC Healthcare 1 is part of this group and is a GP surgery with four female salaried GPs including the lead clinician, pharmacist, junior pharmacist, nurse prescriber, practice nurse, and two healthcare assistants. It is located in a building shared with four other practices, walk in centre, pharmacy and other community healthcare facilities. One of the practices is another DMC Healthcare GP surgery and all the staff, facilities and equipment are shared with this practice.

DMC Healthcare 1 offers a number of services such as family planning and travel advice and immunisations. They hold several specialist clinics including smoking cessation and hypertension.

The practice provides primary care for over 1300 patients within the Stratford area of east London. The practice has 60% Asian and 40% black and minority ethnic patients who are predominantly female. Two thirds of the patients are over 40 years old.

DMC Healthcare 1 has opted out of providing out of hours services to their own patients.

## Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. 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 reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We reviewed the NHS Choices website but found there were no comments from

# Detailed findings

people about DMC Healthcare 1. We asked the practice to put comment cards in the reception area, where patients and carers/relatives could share their views and experiences of the practice.

We carried out an announced visit on 4 August 2014. During our visit we spoke with a range of staff, including the practice manager, GP lead clinician, GP, pharmacist, health care assistant and three reception/administration staff. We spoke to six patients. We looked at the practice's policies, procedures and audits. We reviewed management and staff files. 21 people wrote comments on cards which we reviewed. We spoke to other healthcare professionals in the community such as the community matron and a representative of a patient health monitoring service.

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

### Safe patient care

The practice had safe systems in place for reporting and recording incidents. Staff understood their role and the processes for reporting incidents that affected patient's safety. The practice had an incident reporting procedure which defined these incidents, known as significant event analysis (SEA). There was an incident form which staff completed and this included details on discussion and learning points for staff. The practice manager reviewed these events and investigated along with the lead GP or administration lead depending on whether the incident was clinical or administrative in nature.

Safety alerts regarding medicines came into the practice electronically and the pharmacist shared this information with staff.

### Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed the SEA log on the practice's computer database and found that incidents which had outcomes affecting all staff were noted for discussion at practice meetings. We checked the minutes of these meetings and verified that these significant events were discussed and action taken where necessary. One incident involved confidential waste being placed in an ordinary waste bin instead of the confidential waste facility. Administrative staff were reminded of the confidentiality policy.

Procedures were followed to ensure that action was taken when safety alerts were received. The pharmacist was on the central alert system for Newham Clinical Commissioning Group (CCG). When there were safety alert updates for a particular medicine where changes needed to be made, the pharmacist called in the patients taking that medicine, reviewed them and recorded the consultation under a Medicines Healthcare products Regulatory Agency MHRA warning.

### Safeguarding

Safeguarding policies for both children and vulnerable adults were in place. There were contact lists in all consulting rooms and a safeguarding referral pathway and form on computer desktops. Staff knew who the safeguarding lead was and were able to describe the different forms of abuse and how they would report a concern.

The clinical lead GP described concerns they had reported. As well as reporting the information to the appropriate local authority contact, they contacted other health and social care professionals such as the district nursing team and social workers. They followed these reports up every month with the social worker and then ensured that information held on the practice database was updated.

The clinical lead GP was the lead in children and adult safeguarding and trained to Level 3 in child safeguarding which was in line with national safeguarding guidance. However records for other staff identified that not all training for the safeguarding of children and vulnerable adults was up to date. For example, one of the GPs who had started to work at the practice in March 2014 did not have any formal safeguarding training. The nurse prescriber and practice nurse did not have safeguarding of children training.

### Monitoring safety and responding to risk

There was a business continuity plan in place to deal with emergencies which might interrupt the smooth running of the service. The practice manager told us that they tried to ensure continuity of care and did not often use locum staff. When they did they employed clinical staff through an agency and requested staff who had worked there previously to provide continuity of care as far as possible. Part time staff sometimes worked more hours when required to cover annual leave and sickness absence.

Referrals of patients to hospitals for further tests were carried out within 48 hours by the administrative staff or doctor. Urgent referrals were done immediately on the day.

Three years ago the practice had found a lack of monitoring of the electronic mailbox which received patient test results causing a backlog and delay in patients receiving their results. Now administrative staff checked this mailbox every day and allocated results to GPs for review as soon as they arrived.

### Medicines management

When nurses or healthcare assistants (HCAs) administered Prescription Only Medicines eg vaccines, Patient Group Directives were in place in line with relevant legislation.

# Are services safe?

In response to Quality and Outcomes Framework (QOF) data which showed the practice was not performing well in carrying out medicines reviews, the practice appointed a pharmacist in 2013 to ensure patients had appropriate monitoring of their medicines and those on repeat prescriptions were regularly reviewed according to National Institute for Health and Care Excellence (NICE) guidance. QOF lists were now checked on a weekly basis and patients recalled for medicines reviews as necessary. Every day repeat prescription requests were reviewed and those patients in need of a review were contacted. We spoke to one patient who confirmed they received a telephone call, text or letter to come in for their review every four months.

Blood and other test results for patients prescribed anti-coagulants were monitored by the pharmacist before being sent to the clinicians for review. Repeat prescriptions were then issued which was important for ensuring the correct level of medicine was prescribed for this group of patients.

There was a robust system for ensuring security of prescription pads. All pads, including the one in the "home visit" doctor's bag, were logged on an electronic record which one member of staff audited. In rooms which were shared with other practices, prescriptions pads were removed each evening and placed in a locked drawer with random checks carried out to make sure these tasks were completed.

Storage of medicines was inadequate. We found that the emergency room used for the storage of emergency medicines was unlocked so that patients and members of the public were able to access this room. In the drugs cupboard we found out of date medicines. The doctor's bag contained syringes which were out of date in April 2014 and medicines which had gone past their expiry date of July 2014.

Checks on medicines, such as vaccines, stored at the surgery were inadequate. In one treatment room we found a box of vaccines which had expired in July 2014. We reviewed the record staff used for recording medicines checks and found it did not include a section for recording expiry dates of medicines. We discussed this with the practice manager and they told us they would dispose of the expired medicines and replenish the emergency medicines as soon as possible.

The surgery had several fridges used for the storage of medicines. We found they were stored appropriately. There was a clear policy for maintenance of the cold chain and action to take in the event of potential failure.

### Cleanliness and infection control

Safe and effective systems were in place to reduce the risk and spread of infection. The practice was visibly clean and uncluttered throughout. There was easy to clean furniture, equipment, walls and flooring. All the treatment rooms were clean and we were told staff used sanitising wipes to wipe down equipment after seeing patients. There were alcohol hand gel dispensers throughout the premises and guidance on handwashing techniques displayed at wash hand basins. Sharps bins were safely located and assembled and clinical waste was appropriately stored and collected. There were two bodily fluid spillage kits and staff were clear on cleaning responsibilities at times when cleaners may not be working.

We saw evidence that all clinical staff had hepatitis B immunity blood test checks in order to minimise the risk of spreading infections.

The practice had an up to date infection control policy. Staff had carried out infection control training and the nurse prescriber was the nominated infection control lead. We saw the results of two infection control audits which had been carried out within the last year on the whole building and included facilities and equipment used by the practice. The audits had identified a number of minor shortfalls which had been actioned. There were cleaning schedules and cleaning audits were regularly undertaken.

### Staffing and recruitment

As staff were shared with one of the other surgeries within Vicarage Lane Health Centre, this provided a wide skill mix of staff such as a nurse prescriber and pharmacist. Within the non-clinical side there was a summariser (staff member who summarised all medical notes and letters) and all the other staff were multiskilled to cover a range of tasks. At times locum staff were employed but generally part time staff covered for one another during busy periods.

Staff who had most recently been employed told us they underwent a period of induction training. We checked practice management files and saw there was an induction policy and checklist. Locum GPs received an induction pack. All clinical staff underwent criminal records checks before they started to work at the practice. Management

staff had carried out a risk assessment and judged that non-clinical staff did not require these checks, because they were never left alone with the patient. We saw that other checks on identity were carried out when staff were recruited.

### Dealing with Emergencies

We were told that all staff underwent annual mandatory training in basic life support (BLS) which included training on the defibrillator. We checked staff records and found the nurse prescriber and a doctor who had started to work at the practice in March 2014 had not undertaken update training in basic life support which had been due in February 2014.

All staff including non-clinical staff were able to describe how they would react in the event of a medical emergency where the emergency medical kit was stored. We checked where the kit and emergency medicines were stored and we found syringes and needles which were out of date from February 2014 and a corticosteroid which expired on 11/2013. We found some emergency medicines within the emergency room which were out of date.

An anaphylaxis kit was within its use by date, accessible and available for use.

Fire safety drills and checks of the alarm system were regularly carried out within the building and two staff members were trained and nominated fire marshalls.

### Equipment

We found there were arrangements in place for checking equipment, other than emergency equipment, within the practice. We saw test and calibration records for equipment, such as scales and blood pressure machines, which demonstrated they were regularly serviced and calibrated.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Promoting best practice

Clinical staff received updates such as NICE (National Institute for Health and Care Excellence) guidelines relating to best practice or safety alerts electronically or when attending meetings and training. They also attended "cluster" meetings within the locality and benchmarked their outcomes with other practices. We saw evidence of regular clinical and medicines management review meetings within the practice where they discussed guidance updates, audits, significant events and care pathways. They used several care pathways for patients with conditions such as polycystic ovaries and dementia, and these were discussed and managed on a computerised document management system.

Patients we spoke to, who completed comment cards or responded in surveys felt that they received good care and supported to make informed choices about their care.

Care was delivered in line with current legislation and nationally recognised evidence-based practice. Staff were familiar with the principles of the Mental Capacity Act 2005 and the Gillick competencies. The clinical lead GP showed us anonymised patient records where consent and patient response had been recorded.

### Management, monitoring and improving outcomes for people

The practice manager carried out a number of audits aimed at improving management of patient records and information held in the practice. For example, monthly scanning audits (documents received in the practice such as patient reports from hospitals) were undertaken and any errors identified such as documents scanned to the wrong patient, were discussed with the individual staff who scanned the documents.

There was a system in place for completing clinical audit cycles. Clinical audits were carried out quarterly to a standardised format which was held in a document management system on the computer database. Examples of clinical audits undertaken in 2014 included chronic obstructive pulmonary disease (COPD) and asthma because of high rates of both of these in patients in the practice. The clinical lead GP also carried out referral audits and identified that consent was not always being recorded in patient records. Action was taken to improve this. In 2012 the practice carried out a language barrier audit because doctors had found that they did not have enough time to consult with patients who had a limited understanding of English, who attended with an interpreter. The outcome was that double appointments were now booked with these patients to ensure their health needs were properly assessed. The feedback from patients and doctors was that this had improved their consultations.

### Staffing

The practice operated effective recruitment procedures. The practice manager described the steps the practice undertook for all clinical staff before employing them; this included checking the relevant medical and nursing registers to ensure staff were up to date with their revalidation and registration. We verified that clinical staff were registered and within their revalidation dates.

Regular clinical and medicines management meetings were held as well as meetings for non-clinical staff although some staff attended both so that information and updates were conveyed to all staff.

All staff told us they received an annual appraisal although there were no formal supervision meetings. The nurses and pharmacist had their appraisals with the lead clinician who also supervised the work of the other GPs. There was mixed opinion among the staff we spoke to with some staff who felt supported and able to develop their skills and professional training and others who did not feel they had this opportunity. We saw that there was a whistleblowing policy in place and staff told us they were aware of its purpose and how to report a concern.

We reviewed staff training records and found that staff had undertaken a range of training courses such as records management and spirometry. There was a staff training matrix which did not include all staff and showed that some staff were not up to date with mandatory training such as vulnerable adults safeguarding and basic life support.

The building was maintained by the owner and the practice manager told us they had regular meetings with them regarding facilities, equipment and cleaning. We saw evidence that equipment such as scales and blood pressure machines were regularly serviced and calibrated.

### Working with other services

Clinical staff told us they had frequent engagement and communication with other healthcare providers; the lead

# Are services effective?

## (for example, treatment is effective)

clinician was the lead on patients with substance misuse and worked closely with the pharmacist and local Newham Drug and Alcohol Service to coordinate care for this patient group. They also liaised with the Community Mental Health Team who were in the same building and members of this team had started to attend practice clinical meetings.

Care for patients was integrated with the out of hours provider, Newham GP Cooperative, and practice staff told us that if they had visited a patient the information arrived in the practice by 8 am next day so that patient records could be updated. One patient we spoke with told us they had accessed this service and felt it worked well.

GPs used a risk tool developed within Newham for patients with long term conditions such as diabetes. Multidisciplinary team meetings with other community healthcare professionals were held throughout the year and doctors shared careplans to facilitate coordinated care for patients and prevent admissions to hospital. Before the inspection we spoke to the Community Matron and they confirmed they attended meetings and met with clinicians from the practice to discuss the needs of patients in their joint care.

The practice had systems in place for managing blood and other test results. Results came into a general electronic mailbox box which was monitored every day. They were then allocated to the GP who saw the patient and if they were not available to another GP. In this way, results were reviewed and if significant, further action such as calling the patient in was carried out in a timely manner.

### Health, promotion and prevention

All new patients were given a consultation to ascertain details of their past medical and family histories and this included a general health check. The healthcare assistant contacted all over 75 year olds and under 16 year olds who had not attended the practice recently, and offered them health checks. Carers for patients (such as those with dementia) were also assessed, placed on a register and offered health checks. Patients were offered vascular risk assessments so that preventative measures could be taken for those found to be at high risk of developing cardiovascular disease (CVD).

The practice website had information on a range of health conditions, such as coronary heart disease, with links to educative videos. A number of clinics were held for health promotion and prevention such as smoking cessation, child health surveillance and general sexual health advice. Seasonal flu vaccinations clinics were held to offer patients flu injections. Two patients we spoke to said they had been offered health advice and one patient had been helped to stop smoking.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

During the course of our inspection we observed staff in the reception area speaking to patients respectfully and sympathetically even though it was a busy, noisy environment and a shared reception with the other services in the building.

All the patients we spoke with during the inspection and members of the Patient Participation Group (PPG) we spoke with before our visit, told us that the doctors and staff treated them with dignity and care. One patient told us that during a difficult personal period they were treated with empathy by the staff who took more time with them. Comment cards completed by 21 patients reported positive experiences with regard to care and respect. There was a procedure for ensuring that patients who had passed away had a note put on their records and all correspondence was dealt with so that relatives did not receive letters for the deceased. Sympathy cards were sent to bereaved relatives.

Reception staff told us that if a patient wanted to speak to them confidentially, they would take them to a room next to reception to do so. There was no information on display to inform patients of this service. Similarly, although there was a chaperone policy and reception staff had received specific training in chaperoning, there was no information about this in the reception area or the treatment rooms notifying patients. We discussed this with the clinical lead GP and they said that as it was a shared area they were not able to put information up about their services although clinical staff always asked and noted in records if patients wanted to have a chaperone present. There was information about chaperoning in the practice leaflet and on the practice website.

In treatment and consulting rooms, clinicians told us that privacy curtains and window blinds were used to preserve privacy for patients.

### Involvement in decisions and consent

Staff took all reasonable steps to enable people to make decisions about their own care and treatment wherever possible. Patients described being supported to understand their diagnosis and being given options for care and treatment. One patient told us they got all the help they could and discussed their test results with the doctor. They were then given a copy of the results to enable them to understand and manage their own health better.

Staff were familiar with the principles of the Mental Capacity Act 2005 and the Gillick competencies. The practice had a consent protocol and the clinical staff we spoke to told us they always asked for consent and noted it in patient records. We saw evidence of this in an anonymised patient record.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The premises were designed to meet the needs of patients with poor mobility. There was level access to the practice and disabled toilet facilities. Treatment and consulting rooms were on the ground floor. The entrance and reception area were spacious enough to accommodate people with pushchairs and wheelchairs. For those patients who were hard of hearing an induction loop system was available and patients who were visually impaired were flagged on the database so that staff could alert them as they were unable to see the information screen in the waiting area.

As it was a shared reception area there were signs indicating which desks to attend for the practice. An interpretation service was extensively used for patients with a poor understanding of English and one patient we spoke to told us they had used this service although now preferred to attend with a friend. There was no information displayed in languages other than English in the reception area.

DMC Healthcare 1 had a relatively small practice population who were predominantly female and black and minority ethnic. It also had 70% of patients who were older than 40 years and planned services to accommodate their needs. For example, vascular health checks were offered as well as diabetes and asthma clinics. Older patients and those who were housebound were identified on the patient database and telephoned every month if they had not been to the practice recently, to ask if they had any needs regarding their healthcare.

The practice ran several specialist clinics such as hypertension, family planning and smoking cessation. Patients were able to use other services within the building, which they told us they found convenient, such as phlebotomy (a service to enable patients to have blood tests) and the walk-in centre.

For those patients who were homeless or transient within the area, staff explained that they initially referred them to a transitional team within the building for registration. This team were able to rapidly carry out the necessary checks and registered them then refer them back to the practice. Staff told us they took more time and offered to speak to patients with learning disabilities or dementia in a quieter area. The practice employed only female GPs and nurses so that patients were not able to request to be seen by a male clinician.

The practice had a Patient Participation Group (PPG) and two meetings had been held in 2014. The issues discussed were the telephone system, staff/patient security and lack of appointments. Reception staff told us they had increased the number of time slots allocated each day for urgent appointments as a result of PPG meetings.

### Access to the service

The practice shared their building with four other GP practices, walk-in centre and a number of other community health services. Staff told us they were not able to display information about opening times or provide other information for patients within the reception and waiting areas as these were shared. A practice leaflet was available on request and this detailed information about the services provided, registering of new patients and contact details. There was also a website which was shared with the other practice at Vicarage Lane and stated the opening times as 8am until 8pm seven days a week. Surgery times were available from 9am to 6.30pm Monday to Friday apart from a Tuesday when they were available until 7.30pm. Outside these times an out of hour's service operated and this was advertised in the practice leaflet and website.

Telephone access to the practice for patients was poor. There was a different telephone number on the website and practice leaflet compared to that advertised on the electronic information screen in the waiting area. The practice manager told us that patients knew the two DMC services shared staff and facilities and understood they could access the surgery with either telephone number. They said it was hoped the two services would be merged from April 2015.

Before our visit we reviewed the results of the National GP survey carried out in 2013/14 which found that over 60% of patients found it difficult to make an appointment by telephone. We found the same with the patients we spoke to or who completed comment cards who said they found it difficult to make an appointment by telephone and had to wait a long time to be seen. Before the inspection CQC staff telephoned both telephone numbers and found it difficult to get through to the practice. They telephoned on

# Are services responsive to people's needs?

## (for example, to feedback?)

several occasions and at different times during the day and sometimes waited for over six minutes before being cut off. There was no telephone message to inform patients that the line was busy or they were in a queue.

Senior management staff were aware of the telephone access problem and said that they were unable to have access to telephone data and could not resolve the situation because the building was owned and managed separately. They could not monitor or redirect calls or install another telephone line. This had been an issue for over five years and caused a lot of verbal, and some formal complaints, from patients during that time. The clinical lead GP told us they had raised it with the provider, owners and managers of the building many times. Although discussions were ongoing with the owners of the building and NHS England, there was no action plan in place with agreed timescales, to resolve this matter.

Some patients told us that if they wanted to see a doctor urgently they would have to attend the surgery in person and could go to the walk-in clinic if emergency appointments were not available. GPs were available for home visits for patients who could not attend the surgery and telephone consultations were offered on a ring back basis.

The mix of staff employed at the practice reflected the community practice population and staff were aware of patient's specific needs and were able to give them advice, during for example the period of Ramadan.

There was a system for following up test results with secondary care and one patient told us that the practice nurse had telephoned the hospital to chase up results as they had not received them. Several patients found it convenient that practice staff telephoned or texted them to remind them to come for a medication review or make an appointment if their test results were significant.

### 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.

However, information on how patients could make a complaint was in the practice leaflet but again this was not the same information as on the website in terms of who patients should contact in the first instance. Practice leaflets and complaints/comments forms were not on display and available for patients at reception unless they requested them.

We reviewed the complaints log. No formal complaints had been reported in 2014 and we reviewed two which had been recorded in 2013. Notes had been made that these events should be discussed at practice meetings and we found evidence that this had happened. Because of the shared services and staff with the other practice some of the events reported for this practice had outcomes which also affected the other practice. An example of this was a complaint about reception staff regarding customer service and resulted in staff receiving further training in customer care, which included conflict resolution.

One patient we spoke with told us they did make an informal complaint and met with the practice manager. They felt their complaint had been dealt with satisfactorily.

# Are services well-led?

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

## Our findings

### Leadership and culture

The clinical lead GP had governance meetings every six weeks with a partner GP in DMC Healthcare 1 and we saw evidence of regular clinical and whole practice meetings. Staff were able to tell us of similar general aims which were to provide good patient care and improve it, although the practice did not have a formal mission statement or set of organisational objectives which was communicated to staff.

Many staff had worked at the practice for a number of years and there was a low staff turnover. Most staff felt supported and able to develop although some staff felt undervalued and not provided with the opportunity to further develop their skills.

### Governance arrangements

When we asked practice staff about governance arrangements they were clear about who was responsible for each area. When asked they knew who the responsible leads were for various areas such as safeguarding and infection control. Staff were aware of who was responsible for making specific decisions and also when they themselves were responsible, for example when reporting a safeguarding concern.

### Systems to monitor and improve quality and improvement

There were regular governance meetings where the issue of the poor telephone system was brought to the attention of the partner GPs, who were the senior management, because it generated many of their patient comments, informal complaints and was highlighted as a problem for patients in the patient satisfaction surveys. However, despite these meetings the staff within the practice felt little had been done over five years to improve the situation.

Staff told us that because DMC Healthcare 1 and the other practice operated separately (although staff, facilities and equipment were shared) this meant that work was sometimes duplicated and more work was generated for staff in trying to keep the patient lists separate. They had been in talks with NHS England to merge the practices and hoped this may happen from April 2015. Staff and the PPG were kept informed of the progress of this proposal.

The provider was not subject to external peer review.

### Patient experience and involvement

The practice manager monitored patient comments on the NHS choices website but had not received any reviews as yet. We noted that they had responded to comments on the other DMC practice.

Annual patient surveys were carried out by an independent research company and the practice carried out its own surveys. The last one was carried out by the practice in March 2014 and analysis of the results indicated that 40% of patients found the telephone access to the surgery was poor. Two patients we spoke to confirmed they had been asked to complete a survey.

Patient surveys were followed up and steps taken to address issues identified. The main issue in the last few years apart from telephone access, had been patients wanting to have more urgent appointments during the day and the practice had responded by using nurse practitioner slots to create more appointments. They had also altered staff rotas to put more staff on the rota to answer telephones at busy times.

### Staff engagement and involvement

The PPG was a joint group with the other practice at Vicarage Lane. They had met twice in 2014. The practice manager and members of the group told us they discussed issues such as the phones and security.

There were no formal staff surveys. Staff/patient security in the reception/waiting area had been an area of concern and staff management had liaised (with the other services in the building) with the community police to increase patrols in the area so that they were able to respond more swiftly to alerts raised. Staff felt this had improved security. The clinical lead told us that procedures had been improved for GP security in response to significant incidents within consulting rooms. They had tested the system and other staff now responded immediately to any alerts raised by doctors.

The practice had a whistleblowing policy and staff were aware of it and had access to it on their computer desktops.

### Learning and improvement

Staff objectives were set out during their appraisals which were held every year in March. There was evidence that practice performance was reviewed and discussed at clinical governance meetings.

# Are services well-led?

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

Lessons were shared internally through minuted meetings and externally through the CCG peer review meetings.

### Identification and management of risk

The practice monitored QOF and local benchmarking data to identify areas for improvement. For example they found that patients with dementia or cognitive impairment were omitted from search results on the database and so then included them in their assessments of patients with long term conditions.

# 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

All older patients over the age of 75 years had a named GP. Older patients and those who were housebound were identified on the database. Each month the healthcare assistant telephoned those who had not been in contact with the surgery recently to ask how they could help with their health needs. Home visits were offered to those who were housebound or too ill to attend the surgery.

A carer's register was maintained. Carers for older patients and those at the end of their lives, were also offered a health assessment. Flu jab vaccination clinics were held annually and carers for older patients were offered this service.

There was regular contact with the palliative care nurse and district nursing teams which gave clinical staff the opportunity to coordinate and review care and treatment needs for those patients on the palliative care register. We saw evidence that the practice worked with multidisciplinary teams. Meetings were held to discuss strategies and care plans for older patients at risk of emergency hospital admissions.

# 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 supported patients with long term conditions. Dedicated clinics were available for patients with hypertension, asthma and diabetes. All patients with heart disease received an annual review and were offered a referral to health trainers for healthy lifestyle advice.

GPs used a risk tool developed within Newham for patients with long term conditions such as diabetes. Multidisciplinary team meetings with other community healthcare professionals were held throughout the year and doctors shared careplans to facilitate coordinated care for patients and prevent admissions to hospital.

Patients with conditions such COPD and diabetes were offered a remote monitoring service by an independent company on referral by a GP. This company set up fixed or mobile units in patients' homes to measure and monitor temperatures, blood pressure and other vital information for clinical review at a remote location. The aim was to give patients more control and understanding of their long term health condition and doctors were able to manage interventions and help to improve patient quality of life.

The pharmacist had an overview of all patients on repeat medicines and looked at this information every week. They called patients if there were any concerns. Some patients we spoke to who had long term conditions told us they received phone calls, letters and texts to remind them to make an appointment for a review. They felt they had regular reviews and clinical staff explained information and gave them printouts of their results to enable them to understand their results more easily.

# 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

Child health surveillance clinics were held to monitor child development and administer vaccination and immunisations for new born babies, one year olds and pre-school children. Clinical staff communicated with the health visitor and district nursing teams to provide coordination of care. The practice did not have its own midwife but doctors did refer mothers to a midwife clinic run within Vicarage Lane Health Centre every week, for antenatal and postnatal care.

The child safeguarding lead attended safeguarding meetings with multidisciplinary teams to share information and improve the safety of vulnerable children. All staff were aware of child protection safeguarding procedures and informed appropriate authorities when necessary. They used the practice database to highlight vulnerable children and their families so that all staff would have access to up to date information.

Staff were aware of the Gillick competency. This meant that they understood some children could give informed consent when appropriate and that a person with parental responsibility gave informed consent otherwise. The clinical lead told us about an example when they had assessed a 15 year old as competent and given them advice. This assessment was noted in the patient's records. The practice had a teenager confidentiality policy and the healthcare assistant contacted under 16 year olds who had not been into the practice recently to offer them a health check.

# 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 responded to the needs of working people by offering appointments from 9am to 6.30pm Monday to Friday with the exception of Tuesday night when the practice had appointments until 7.30pm. Patients found appointment times convenient and said they could get an urgent appointment on the day by coming to the practice and if they had no more appointments available they could attend the walk-in clinic. In response to patient feedback from surveys more emergency appointments were introduced in the mornings. Patients could email the practice to make an appointment but there was no online appointment booking. Online repeat prescription requests were available for those patients who found it difficult to access the practice on telephone or in person.

Patients were offered vascular risk assessments so that preventative measures could be taken for those found to be at high risk of developing cardiovascular disease (CVD).

# 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

We spoke to reception staff who told us there were no barriers to accessing the practice for patients such as those who were homeless or who did not have the correct information such as ID/proof of address in order to register as patients with the practice. In the first instance they were transferred to a "transition" team who were located within the building. This team worked for all the practices, walk-in centre and other services to make checks and carry out the initial registration of a patient. Once this was completed they transferred them back to the practice so that they could be seen by a clinician.

The pharmacist and GPs at the practice worked closely with the Newham Drug and Alcohol Service to support vulnerable patients such as those who misused drugs and alcohol.

Carers, for example for those patients with a learning disability were registered on the database so that all staff had access to that information when a patient attended the practice. Staff were aware of the principles of the Mental Capacity Act 2005 and understood they needed to obtain patient consent. They took time to listen to patients such as those with learning disabilities and understood their needs.

Although there was a vulnerable adults policy and procedure in place not all staff had received training in the safeguarding of vulnerable adults.

# 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

Before our inspection we looked at data which highlighted the practice was poor at carrying out depression assessments on patients. In 2013 the practice engaged a pharmacist to review patient records to identify these as well as other patient groups. This had led to an increase in the number of depression assessments undertaken.

Patients with poor mental health had annual reviews and health checks. The pharmacist and GPs worked with the Mental Health Community team which was located in the building. They had recently invited some of these staff to attend their practice meetings to improve liaison and communication between them. Doctors monitored those patients who took lithium.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br>**The provider did not protect patients and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the provider to identify, assess and manage risks relating to the health, welfare and safety of patients and others because the telephone system was inadequate. Information for patients regarding contact information and appointment times were inconsistent. This did not enable patients to reasonably contact the provider by telephone to access care.**<br>Regulation 10(1)(b) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>**The provider did not protect patients against the risks associated with the unsafe use and management of medicines because they did not ensure medicines were stored securely and some medicines were outside their expiry dates.**<br>Regulation 13 |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff |

This section is primarily information for the provider

# Compliance actions

Treatment of disease, disorder or injury

The provider did not have suitable arrangements in place to ensure that staff received appropriate training because some clinical staff did not have training in basic life support and safeguarding.

Regulation 23(1)(a)