

Docklands Medical Centre

Quality Report

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Date of inspection visit: 20 November 2014

Date of publication: 21/05/2015

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

Ratings

Overall rating for this service		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Docklands Medical Centre on 20 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia). We found the practice to be providing good services for working age people (including those recently retired and students).

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment;
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles;

- The practice had good facilities and was well equipped to treat patients and meet their needs;
- The practice had recognised the needs of different groups in the planning of its services. For example, staff could outline how they helped vulnerable patients who needed additional support to understand and be involved in their care;
- There was a strong focus on continuous learning and improvement at all levels of the organisation. For example, the practice was part of a network of four local practices which allowed the practice to share clinical best practice.

However there were areas of practice where the provider needs to make improvements. Importantly the provider must:

- Carry out Disclosure and Barring service (DBS) checks on all staff who undertake chaperone duties at the practice.

In addition, the provider should;

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- Include complaints procedure information on its website and translate existing complaints posters in reception into local community languages;

- Ensure all staff who undertook chaperone activities are suitably trained.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses including safeguarding concerns. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients and staff were assessed and well managed such as for example undertaking infection prevention and control audits. There were enough staff to keep people safe. Non clinical staff undertaking chaperone duties at the practice had not undergone Disclosure and Barring service (DBS) checks.

Good



Are services effective?

The practice is rated as good for providing effective services. Data we looked at before our inspection showed that patient outcomes were at or above average for the locality. Performance on unplanned hospital admissions for diabetes and coronary heart disease were better than the average for practices in Tower Hamlets Clinical Commissioning group (CCG) area and nationally.

Peoples' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams and used guidance from the National Institute for Health and Care Excellence (NICE) to improve patient outcomes. We saw evidence that clinical audits were being completed and used to help improve patient outcomes but noted the practice lacked a systematic programme of undertaking clinical audits at regular intervals.

Good



Are services caring?

The practice is rated as good for providing caring services. We saw that staff treated patients with kindness and respect and that the percentage of patients who would recommend the practice was higher than the average for Tower Hamlets area. Staff explained how they helped patients requiring additional support to understand and be involved in their care. Patients we spoke with told us that the doctors and nurses provided sufficient information to be able to make informed decisions about their care and treatment. They told us that that us they were treated with compassion, dignity and respect.

Good



Summary of findings

Are services responsive to people's needs?

Good



The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with Tower Hamlets Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good physical facilities (such as wheelchair access, baby changing facilities) and was well equipped to treat patients and meet their needs. For example, longer appointments were offered for those that needed them and we saw that urgent same day appointments were available but not usually with a named GP.

The practice worked with three other local practices which enabled it to offer treatments by clinicians from other practices that had a particular clinical specialism such as minor surgery or contraceptive implants.

Information about how to complain was available and easy to understand and we saw evidence that the practice responded quickly to issues raised. For example, PPG members told us that the practice waiting area had been redesigned based upon their feedback. We also saw some evidence that the practice learned from complaints and used this information to improve the service.

Records showed that the practice involved its Patient Participation Group in how it planned and delivered the service. Members spoke positively and gave examples of how their views had been sought and taken on board.

Are services well-led?

Good



The practice is rated as good for being well-led. There was clear leadership and staff told us they felt supported by management. The practice had a clear vision and clinical and non clinical staff could explain how their roles and responsibilities contributed to this vision.

The practice had a number of policies and procedures to govern activity and we noted that the senior salaried GP undertook lead roles such as safeguarding and significant events; supported by an Area Manager based at the practice. There were systems in place to monitor and improve quality including weekly clinical meetings where performance on patient outcomes was reviewed.

There was a strong focus on continuous learning and improvement at all levels of the organisation. Clinicians undertook part time undergraduate teaching, post graduate teaching and nurse mentor roles and staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice. Quarterly

Summary of findings

clinical governance meetings also took place where complaints and significant events for all practices in the Hurley Group were reviewed and lessons shared through monthly practice meetings and quarterly staff newsletters.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance (including the Mental Capacity Act 2005). We noted that at 80%, the practice's performance on the percentage of patients with dementia who had had a face to face review in the preceding twelve months was slightly better than the 78% England practice average.

We also noted that at 78%, the percentage of patients aged 65 and older who had had a seasonal flu vaccination was above the 73% England practice average. However, nationally reported data showed that the practice performed below the England practice average for dementia diagnoses rates (27% and 54% respectively).

We noted that the practice was responsive to the needs of older people offering, for example home visits, rapid access appointments and extended appointment slots. Older patients spoke positively about how they were treated by staff. Patients aged over 75 had their own named GP and were offered annual health checks.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. We noted that 27% of patients in the practice list had a diagnosed long standing health condition and the practice outlined how it worked to improve outcomes. For example, we were told that longer appointments and home visits were available when needed. Patients had a named GP and practice nurses regularly reviewed patients on long term condition registers to check that their health and medication needs were being met. Patients with long term conditions told us that clinicians provided sufficient information to enable them to make informed decisions about their care and treatment. This was also consistent with NHS England 2014 national patient survey data.

We noted that QOF performance was above the Tower Hamlets and England averages on aspects of a range of chronic disease management, including unplanned hospital admissions for diabetes and coronary heart disease and for patients with heart rhythm disorder who had had a recent stroke risk assessment. However we also noted that the practice performed below local and national averages for the percentage of patients with dementia who had had their care reviewed in the last 12 months.

Good



Summary of findings

Records showed that QOF performance data was routinely used at weekly clinical meetings to monitor and review patient outcomes. We also saw evidence of how practice staff worked with other health care professionals such as district nurses to deliver a multidisciplinary and coordinated package of care.

The practice was part of a network of four local practices and we were told that this allowed the practice to offer treatments by clinicians from other practices who had a particular clinical specialism such as minor surgery or contraceptive implants.

Families, children and young people

The practice is rated as good for the care of families, children and young people. Immunisation rates at 12 months, 24 months and 5 years were better than the average for practices in Tower Hamlets CCG area. Appointments were available outside of school hours and the premises were suitable for children and babies (for example baby changing facilities were available). Records showed that the practice worked closely with midwives and school nurses and that a children at risk register was kept and regularly reviewed. The practice worked as part of a local federation and the practice nurse spoke positively about how this enabled a range of best practice to be shared (including child protection and safeguarding). Practice staff were aware of local safeguarding contacts and knew how to escalate concerns. The practice also ran a drop in sexual health clinic which was particularly responsive to the needs of young patients. The nursing team specialised in chronic disease management. The percentage of patients under 18 was lower than the local CCG average.

We spoke with a health visitor who delivered a weekly baby clinic from the practice. They spoke positively about how the practice resourced the clinic and also about its proactive approach to involving health visitors in multi-disciplinary meetings.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). We noted that many patients were of working age and that the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included telephone consultations, early morning appointments and online appointment booking and repeat prescriptions facilities. We noted that the practice offered a full range of health promotion and screening that reflected the

Good



Summary of findings

needs of this age group. Health promotion material was available throughout the practice including via a TV in the patient waiting area. The practice's website contained links to NHS Choices healthy living advice webpages.

The practice had recently introduced a daily minor ailments clinic run by its nurse practitioner and also offered a telephone triage and call back system so that patients could speak to either the nurse practitioner or a GP for telephone consultation. A tele health service was also available: providing patients with an online minor ailments diagnostic and self-help service.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances. Patients with a learning disability were offered annual health checks and longer appointments.

When we spoke with a patient with a physical and learning disability they were positive about how staff treated them and about how care and treatment options were explained (including the use of "easy read" pictorial leaflets). Their relative also spoke positively about wheelchair access and the length of appointments.

Staff knew how to recognise signs of abuse in vulnerable adults. They were also aware of their responsibilities regarding information sharing, documenting safeguarding concerns and contacting relevant agencies in normal working hours and out of hours. The practice offered interpreting services in a range of languages including British Sign Language (BSL).

We noted that 24% of patients in the practice list had a caring responsibility (above the England average). We were told by staff that the practice signposted patients requiring support to a local carer support network. We also noted that carers information was provided in the practice reception and on the practice website.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

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

Good



Summary of findings

the England average. The practice kept a register of patients experiencing poor mental health and GPs stressed the importance of reviewing patients' physical as well as mental health. We noted for example that at 79%, the practice performed better than the Tower Hamlets' practice average of 72% for the percentage of patients with poor mental health whose notes recorded that they had had a cervical screening test in the preceding five years.

The practice offered flexible appointments such as evening appointments (when the practice was less busy) as we were told that this was preferred by many patients experiencing poor mental health. The practice also had systems in place to support patients presenting with acutely poor mental health and also routinely signposted patients with less severe symptoms to specialist local voluntary sector organisations. We noted that at 64%, the practice's QOF performance was better than the Tower Hamlets practice average of 58% for patients with a new diagnosis of depression who had had a review not later than the target 35 days after diagnosis.

Summary of findings

What people who use the service say

During our inspection, we spoke with four patients who were all positive about the care and treatment they received and with the practice environment. Two of the patients were also members of the practice's Patient Participation Group (PPG) and gave examples of how the practice had acted upon patients' concerns.

We also reviewed 27 patient comments cards. These had been completed by patients in the two week period before our inspection and enabled patients to record their views on the practice. Feedback was generally positive with key themes being that staff were respectful and that the practice environment was clean.

Appointment availability was identified as an issue in the 2014 NHS England national patient survey (85

respondents). We noted that only 39% of patients with a preferred GP got to see that GP (compared with the 53% local practice average). Similarly, 30% of the 65 respondents to the practice's own 2014 annual patient survey highlighted ease of getting an appointment as an area of concern (in addition to waiting times and interpreting services publicity).

Overall however, patient feedback was positive. For example, 84% of NHS England national patient survey respondents fed back that they would recommend the surgery to someone new to the area (compared with the Tower Hamlets practice average of 72).

Areas for improvement

Action the service **MUST** take to improve

- Carry out Disclosure and Barring service (DBS) checks on all staff who undertake chaperone duties at the practice.

Action the service **SHOULD** take to improve

- Include complaints procedure information on its website and translate existing complaints posters in reception into local community languages;
- Ensure all staff who undertook chaperone activities were suitably trained.

Docklands Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector**. The team included a GP granted the same authority to enter Docklands Medical Centre as the Care Quality Commission (CQC) inspector.

Background to Docklands Medical Centre

Docklands Medical Centre is located on the Isle of Dogs in Tower Hamlets, East London and has a patient list of approximately 6,600. It is part of the Hurley Group of seventeen GP surgeries in the Greater London area. Five percent of patients at the practice are aged 65 or older (compared with 16% nationally) and 16% are under 18 years old (compared with 21% nationally). Twenty eight percent of patients have a long standing health condition and 24% have carer responsibilities.

The services provided include child health care, ante and post natal care, immunisations, sexual health and contraception advice, management of long term conditions and smoking cessation clinics.

The staff team comprises a senior salaried GP (male), two salaried GPs (one female, one male), nurse practitioner (female), practice nurses (female), practice manager and a range of administrative staff.

The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities. The practice has opted out of providing out-of-hours services to their own patients.

Public Health England's Tower Hamlets 2014 Health Profile notes that the health of people in the borough is variable. Tower Hamlets is the third most ethnically diverse borough in England.

The health of people in Tower Hamlets is varied compared with the England average. Deprivation is higher than average and about 43.6% (22,400) children live in poverty. Life expectancy for both men and women is lower than the England average and life expectancy is 6.9 years lower for men in the most deprived areas of Tower Hamlets than in the least deprived areas.

By the time children reach age ten, 26.5% (690) of children are classified as obese which is worse than the average for England. Levels of breastfeeding and smoking at time of delivery are better than the England average.

Rates of sexually transmitted infections and Tuberculosis are worse than average.

In Tower Hamlets, strategic improvements in health and wellbeing are led by the borough's Health & Wellbeing Board; comprised of Tower Hamlets Council, Tower Hamlets Clinical Commissioning Group, Tower Hamlets Healthwatch and other health stakeholders.

The practice is registered to provide the following regulated activities which we inspected: treatment of disease, disorder or injury, diagnostic and screening procedures, surgical procedures, family planning, maternity and midwifery services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was

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planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 November 2014. During our visit we spoke with a range of staff (salaried GPs, practice nurse, practice manager, administrative staff, reception staff and the area manager) and spoke with four patients including two PPG members. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients shared their views and experiences of the service.

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety including reported incidents and comments/complaints received from patients. Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, a practice nurses' outline of how they would report a sharps injury was consistent with the practice's infection control and prevention policy.

The practice also had a safety alert protocol detailing the procedure for sharing received drugs alerts throughout the practice. Staff knew their roles and accountability in this process. For example, the practice manager confirmed they were on the circulation list for receiving alerts and also outlined their role in ensuring that printed copies were on file.

Learning and improvement from safety incidents

The practice had a system in place to ensure that learning from significant events was shared and used to improve the service. We looked at nine events recorded since July 2013 and noted that the practice recorded the area of concern, outcomes/actions taken and how learning had been shared. For example, records showed that patient registration procedures had been reviewed after a patient with a penicillin allergy had been registered without this information having been recorded.

Records showed that significant events were discussed at weekly clinical meetings as necessary and we noted that the senior practice GP had responsibility for sharing learning amongst practice staff. We also noted that Hurley Group had systems in place so that learning from a significant event at any of its twenty six general practice locations could be shared amongst all practices via quarterly clinical governance meetings and staff newsletter.

Reliable safety systems and processes including safeguarding

There were systems in place which ensured patients were safeguarded from the risk of abuse. The practice senior salaried GP was designated safeguarding lead and the practice had ensured all staff were trained in protecting

vulnerable adults and children from abuse to the appropriate level. For example, GPs were Level 3 trained in child protection and non clinical staff had attended basic children and vulnerable adults safeguarding training.

Staff were able to recognise types of abuse (including in older patients) and knew how and to whom they would report or escalate a concern. The practice had policies for child protection and at risk adults which included local authority and CCG contact details. Staff were aware of these contacts and GPs had experience of contributing to child protection hearings in person or by submitting reports. The nurse practitioner was in regular contact with the borough's health visitors and also spoke positively about how the practice's involvement with a local GP network had enabled best practice in child protection to be shared.

There was a chaperone policy, which was visible on the waiting room noticeboard and in treatment rooms (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were told that some administrative staff undertook chaperoning duties. However, these staff had not undergone Disclosure and Barring Service (DBS) checks. Chaperone training had also not been provided.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example patients experiencing poor mental health.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures including how reception staff received, logged and stored medicines; and actions to take in the event of a power failure. We noted that medicines refrigerator temperatures were recorded on a daily basis and were within the required parameters. Medicines were also within their expiry date and we noted that the practice did not hold Controlled Drugs on the premises.

Cleanliness & Infection Control

Patients were treated in a clean, hygienic environment. All communal and non-clinical areas of the practice were

Are services safe?

maintained and cleaned routinely by a cleaning contractor and we were told that regular monitoring meetings took place. Patients spoke positively about the environment. Consultation rooms had vinyl flooring and we noted that clinical waste was stored securely away from patient areas whilst awaiting collection. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice's nurse practitioner was the Infection Prevention and Control (IPC) lead and responsible for ensuring effective infection control throughout the practice. Practice nurses had attended infection control training within the last twelve months. Personal protective equipment such as gloves and aprons were readily available for staff to use.

The practice had an infection control policy and we noted that in accordance with the policy, infection control audits took place every six months. We looked at the latest infection control audit (April 2014) and were able to confirm for example, that in accordance with audit's action plan, fabric seating in waiting areas had been replaced with vinyl seating

The practice had a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). A Legionella risk assessment had also taken place in June 2014 and we noted that no issues had been identified.

Records confirmed the practice was carrying out regular checks in line with its Legionella policy to reduce the risk of infection to staff and patients.

Equipment

We saw evidence of calibration of relevant equipment within the last twelve months including electronic blood pressure machines, weighing scales and defibrillator. Fire alarm and portable appliance testing (PAT testing) had also taken place within the last twelve months.

Staffing & Recruitment

The practice had systems in place to ensure that staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Electronic records showed that actual staffing levels and skill mix were in line with planned staffing requirements.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We also noted that new staff completed an induction which included infection control & prevention, complaints and the practice's clinical software. Staff told us there were usually enough staff to maintain the smooth running of the practice and we saw evidence that systems were in place to keep patients safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual, bi-annual and monthly checks of the building and equipment, infection control, medicines management, staffing and dealing with emergencies. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk and records showed that identified risks were routinely discussed at clinical meetings. We also noted that the Hurley Group also held quarterly clinical governance meetings where risks were identified.

Arrangements to deal with emergencies and major incidents

There were sufficient systems in place to deal with a medical emergency. The practice had an automated external defibrillator, emergency medicines and emergency oxygen. The medicines were within their use by date and we noted that an allocated nursing staff member undertook regular checks. Clinical staff had received cardiopulmonary resuscitation (CPR) training within the last twelve months. Non clinical staff had received CPR training within the last three years.

Plans were in place to respond to emergencies and major situations. The practice had a business continuity plan which described to staff what to do in the event of an emergency. The plan covered areas such as pandemic flu, fire, staff shortage and IT system failure, and contained relevant contact details for staff to refer to (such as support numbers in the event of an electrical power failure). If the practice had to close urgently, there was a reciprocal arrangement in place with a nearby practice in the Hurley

Are services safe?

Group therefore minimising disruption. Staff were also able to demonstrate how learning from a major incident involving another practice in the Hurley Group had been shared with staff at Docklands Medical Centre.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, allowing the practice to focus on specific conditions. Clinical staff spoke of a practice culture of advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines.

The practice had systems in place to ensure that patients' care and treatment was assessed, planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This included use of Quality and Outcomes Framework (QOF- a national performance measurement tool). For example, QOF data showed that the practice performed better than the Tower Hamlets and England averages for arthritic patients aged 30-84 who had had a cardiovascular risk assessment in the preceding twelve months. Regular cardiovascular checks for arthritic patients are identified as best practice by the National Institute for Health and Care Excellence (NICE). The practice also performed better than the Tower Hamlets and England averages for newly diagnosed patients with depression who had a follow up review within the target 35 days. Dementia diagnosis rates were below the England average but we also noted that at 5.3% the percentage of patients aged 65 plus was significantly lower than the England practice average (16.5%).

Clinicians spoke positively about the practice's involvement in a local network of four practices and how this helped ensure that care was "joined up" and based upon latest clinical guidance. For example, the nurse practitioner told us that newly diagnosed diabetic patients could access a programme of care which included regular checks, an annual care planning consultation and individualised care plans with goals. We noted that practice QOF performance on newly diagnosed diabetic patients referred to an education programme was 100% and also that QOF performance on unplanned hospital admissions rates for diabetic patients was amongst the lowest in Tower Hamlets.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the

culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, sexual orientation, race and religion as appropriate.

Management, monitoring and improving outcomes for people

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 88% of diabetic patients had had a dietary review in the last twelve months compared with the 82% England practice and 87% Tower Hamlets practice averages. The practice also performed better than the Tower Hamlets practice average on a range of indicators regarding care of asthmatic patients and of patients with chronic obstructive pulmonary disease (lung disease).

Staff across the practice had key roles in monitoring and improving outcomes for patients including data input, scheduling clinical reviews, managing child protection alerts and medicines management. Information was collated by the practice manager and used to support the practice's clinical audits.

Three clinical audits had taken place in the last nine months and we noted that two of these audits were ongoing. The completed audit was linked to NICE best practice recommendations on discontinuing repeat prescription of diabetic drug X if a minimum specified blood sugar level reduction had not been achieved within six months. We noted that the first stage of the audit in July 2013 identified a sample of 34 diabetic patients on repeat prescription. The second stage of the audit in March 2014 reviewed blood sugar levels and resulted in three patients immediately being taken off repeat prescription as they had not achieved the specified blood sugar level reduction.

Records showed that the audit had been triggered after Tower Hamlets CCG benchmarked (or evaluated and compared) practice prescribing data with other local practices and identified an anomaly. However, the practice was able to demonstrate how it used the clinical audit cycle to address this anomaly and improve patient outcomes.

The practice performed better than the England practice average in a number of Quality and Outcomes Framework

Are services effective?

(for example, treatment is effective)

(QOF) clinical targets for the year ending April 2014 including occurrence of regular (at least three monthly) multidisciplinary review meetings where all patients on the end of life care register were discussed.

We noted that information about patient's care and treatment, and their outcomes, was routinely monitored and information used to improve care. For example, we noted that the care and treatment of end of life patients was regularly monitored and reviewed.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all staff were up to date regarding mandatory training (for example safeguarding and infection control). We noted a good skill mix amongst the GPs and a mixture of female and male GPs. We noted that GPs were up to date with their yearly continuing professional development requirements and had had their five yearly medical licence revalidation within the last 12 months.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Administrative staff we spoke with had completed annual appraisals within the last 12 months where performance was reviewed and training needs identified. They told us that although formal supervision meetings did not take place, they felt supported in their roles.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. A practice nurse we spoke with outlined their extended role in seeing patients with long-term conditions such as diabetes and coronary heart disease and was also able to demonstrate that they had appropriate training to fulfil this role.

Working with colleagues and other services

The practice had systems in place to help ensure that when care was received from a range of different teams or services it was coordinated. For example, records showed that regular meetings took place with district nurses, health visitors and end of life nurses to monitor and review patient care and treatment. Minutes of clinical meetings showed that clinicians were regularly invited to attend practice clinical meetings. Systems were also in place to signpost or refer patients to specialist third sector agencies including mental health and carer support.

Staff spoke positively about how the practice's involvement in a local network of four practices had enabled some administrative tasks to be centrally shared whilst clinicians fed back that the network enabled them to share clinical best practice.

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care including test results and information to and from other services such as hospitals. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. When we reviewed the system we saw that patients were referred in a timely manner and that all the information needed for their ongoing care was shared appropriately. We also noted that incoming correspondence was processed in a timely fashion. However, there was no formal audit system in place to assess the completeness of records and identify action to be taken where necessary.

Consent to care and treatment

Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance including the Mental Capacity Act 2005. Systems were in place to support patients to make decisions including where appropriate, an assessment of their mental capacity. Systems were also in place for situations where patients lacked the mental capacity; ensuring that 'best interests' decisions were made and recorded in accordance with legislation.

Are services effective?

(for example, treatment is effective)

For example, staff were able to give examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Clinical staff also demonstrated a clear understanding of Gillick competencies (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health Promotion & Prevention

Through its participation in the GP network, the practice could demonstrate how it worked with Tower Hamlets CCG to deliver health promotion priorities identified in the borough's Joint Strategic Needs Assessment (JSNA) and overall Health and Wellbeing Strategy. The JSNA pulls together information about the health and social care needs of the local area and develops action plans based upon these needs. For example, we noted a key target of the Health and Wellbeing Strategy was long term conditions and that the practice's QOF performance was at or above local averages for diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients

registering with the practice. We noted that a range of health promotion activity took place including ante natal clinics, sexual health clinics and smoking cessation. The practice also offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Seasonal flu vaccination rates for patients over 65 was slightly better than the national average. Latest available performance data for immunisations at twelve months, twenty four months and five years was in line with national targets.

Practice performance was above Tower Hamlets and England averages for newly diagnosed diabetic patients who had been referred to an education programme. Performance data on women who had had cervical screening within the last five years was also above the average for practices in Tower Hamlets. QOF performance on patients 65 and older who had received a seasonal flu vaccination was better than the national average (78% and 73% respectively).

We noted that the reception area contained patient information on conditions which were prevalent amongst the local community such as cardiovascular disease and mental health.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We noted NHS England 2014 national GP patient survey feedback that 89% of respondents found receptionists helpful. When we spoke with patients they were positive about how they were treated by reception staff and during our inspection, we observed that reception staff treated patients with dignity and respect.

Patients spoke positively about how they were treated by GPs and nurses. This was consistent with comment card feedback which highlighted staff compassion.

The practice offered a chaperone service which was publicised in reception. Reception staff undertook chaperone duties but had not received training.

During our inspection, we observed that the reception desk was adjacent to the waiting area and that conversations between the receptionist and patients could be overheard. However, none of the responses from either the NHS England 2014 national GP patient survey (80 respondents) or the practice's own 2014 annual patient survey (63 respondents) fed back concerns regarding privacy in reception. Privacy in reception was not identified as an issue during patient discussions or from comment cards.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decisions about their care and treatment and this was also a consistent theme of comment card and survey feedback. The NHS England 2014 national GP patient survey identified that 72% of respondents said that the last GP they saw or spoke to was good at explaining tests and treatments which was below the Tower Hamlets average of 78%.

We also noted that at 34%, the practice's QOF performance was below the national average (86%) for the percentage of patients with physical and/or mental health conditions whose notes had a documented comprehensive care plan on file, agreed between individuals, their family and/or carers as appropriate.

The practice website and reception contained a range of information to help patients make informed decisions about their care and treatment. Staff outlined how they helped patients who needed additional support to understand and be involved in their care.

Staff told us that interpreting services were available for patients who did not have English as a first language. However, these were not well publicised in reception to inform patients that this service was available.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website advised people how to access local and national support groups and organisations. Survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of respondents fed back that the last GP they saw or spoke to was good at treating them with care and concern. This was consistent with face to face and comment card feedback which highlighted that staff responded compassionately and provided support when required; such as during times of bereavement or prolonged treatment.

The NHS England national GP Patient Survey 2014 noted that 87% of respondents fed back that the last GP they saw or spoke to was good at listening to them and treated them with care and concern. We also noted that 84% felt that the last GP they saw or spoke to was good at giving them enough time.

We noted that the practice had systems in place to monitor and review care of palliative (end of life) care patients. The practice signposted patients to organisations providing specialist support such as cancer and diabetes support. Records also showed that end of life care nurses regularly attended multi-disciplinary meetings at the practice to ensure that emotional support and caring support were coordinated. The practice's computer system alerted staff if a patient had a terminal illness, enabling a priority appointment to be booked.

We noted that 24% of patients had a caring responsibility (above the England average). We were advised that the practice routinely signposted patients to a local carer support network and we noted that carers information was provided in the practice reception and on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was aware of its population group profile and used QOF to respond to patient need and improve outcomes. For example, most patients were aged between 20-39 and we noted that the practice had recently introduced a daily minor ailments clinic run by its nurse practitioner. In addition, a telephone triage and call back system had been introduced so that patients could speak to either the Nurse Practitioner or a GP for telephone consultation. A tele health service was also available; providing patients with online minor ailments diagnostic and self-help service.

The practice also offered a range of clinics to meet the needs of its relatively younger patient population including ante natal clinics, sexual health clinics and smoking cessation.

We noted that 27% of patients had a diagnosed long standing health condition and the practice demonstrated how QOF performance data was used to respond to patient need and improve outcomes. For example, QOF performance was better than the national average across a number of patient group areas including unplanned hospital admissions for patients who were diabetic, had heart disease or lung disease.

We also noted that only 5% of patients were aged 65 or older (compared with an England practice average of 16%). This reflected Tower Hamlets' relatively younger population. The practice evidenced how it used QOF to target activity and improve patient outcomes for older people. The practice offered a seasonal "drop in" flu clinic for patients aged sixty five and over; and we noted that QOF performance on patients 65 and older who had received a seasonal flu vaccination was better than the England practice average (respectively 78% and 73%).

Information about the needs of patients using the service was used to inform how services were planned and delivered. The practice had an active Patient Participation Group (PPG - a patient led forum for sharing patients' views with the practice). We spoke with two PPG members who were positive about how their groups' views were taken on board and confirmed that the group had met to consider the results of the 2014 patient survey. We noted that after the meeting, the practice had introduced a minor illness

Saturday clinics and telephone consultation in response to negative patient feedback on appointments availability. However, we did not see evidence of a formal action plan with time scales.

Tackling inequity and promoting equality

The practice was purpose built and had ramped access to allow patients with mobility scooters and wheelchairs to access the practice. Toilets were wheelchair accessible and contained baby changing facilities. The waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the consultation rooms. There was a hearing loop at reception for patients with a hearing impairment and the practice made use of an interpreter service (including British Sign Language interpreters) to ensure patients whose first language was not English could access the service. We noted that not all patients were aware of this service. The reception desk included a lowered section to enable ease of access for wheelchair users and children. We did not see evidence of translated materials in reception such as the practice complaints policy or new patients leaflet.

The practice had recognised the needs of different groups in the planning of its services. The practice offered extended appointments and "easy read" pictorial leaflets for patients with learning disabilities. We asked staff how they would ensure that patients with a learning disability received equitable care. They stressed the importance of eye contact, listening and of seeing each patient as an individual with individual care needs. We also noted that a range of support was offered to carers including signposting to a local carers support network.

Annual health checks were provided for patients who experienced poor mental health and we saw that the practice's QOF performance on cervical screening tests of women experiencing poor mental health was above the Tower Hamlets and England average. The practice also offered flexible services and appointments including for example, evenings appointments (when the practice was less busy) as this was preferred by many patients.

The practice provided text appointment reminders to all patients which we noted was of particular support to patients with a hearing impairment or who were living with dementia. A screen with the name of the next patient to be seen was located in reception to help meet the needs of patients with a hearing impairment.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice offered a range of appointment options to meet the needs of its patient groups including appointment booking by phone, online or in person. Early morning appointments were available Monday and Tuesday (7:00am) in addition to late Wednesday evenings (7.30pm). The practice provided a named GP and extended appointment slots for patients aged over 75 years or who had a learning disability. Home visits were also available as well as telephone consultations.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments online. An on line repeat prescription facility was also available. A tele health service was also available; providing patients with an online minor ailments diagnostic and self-help service.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. For example, if patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. This was also detailed on the website.

Longer appointments were available for people who needed them such as patients with a learning disability and those with long-term conditions. Patients over 75 had a named GP. The practice was part of a network of four local practices and we were told that this allowed the practice to offer treatments by clinicians from other practices who had a particular clinical specialism such as minor surgery or contraceptive implants.

Patients we spoke with were generally positive regarding access; although some comment card feedback expressed dissatisfaction with the practice phone system. We noted that 69% of the 65 patients who completed a practice 2014 patient survey had feedback that they had no difficulty getting through by telephone.

Some patients spoke of difficulty in getting an appointment at short notice. This was also highlighted as an issue in the practice 2014 annual patient survey. We noted that the practice was taking action to improve appointments availability including for example, forming a network with three other local practices to improve appointments access.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Its 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 to the practice.

We saw that information was available in reception and on the practice website to help patients understand the complaints system (although this was only available in English). This included advice on how patients could escalate complaints to the Health Service Ombudsman. Patients told us they were aware of the process to follow if they wished to make a complaint but had not needed to make a complaint about the practice. The complaints procedure was however not publicised on its website.

The practice could demonstrate how it used complaints to improve the service. We looked at seven complaints received since April 2014 and saw that six had a learning outcome and evidence of how the complaint would be used to improve patient outcomes. For example, following a patient complaint about a delayed referral, we saw that learning focussed upon reminding clinicians to double check entries before sending electronic referrals. We noted that complaints trends and learning across the Hurley Group were discussed at quarterly clinical governance meetings.

Are services well-led?

Good 

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver good quality patient centred general practice. We spoke with a range of staff including reception staff, nurse practitioner GPs and the area manager; all of whom described a patient centred approach to delivering care. We did not see evidence of a business plan but discussions with staff highlighted that the practice's focus was upon good quality, patient centred care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We also noted that the salaried GP undertook lead roles (for example on safeguarding and significant events). They were supported by the Hurley Group Area Manager who was based in the same building. We looked at a range of policies including infection control, data protection and safeguarding and noted that they had been reviewed within the last twelve months.

We did not see a record confirming that staff had read the policies but staff generally demonstrated an understanding. For example, the nurse practitioner's explanation of what to do in the event of a needle stick injury was consistent with the practice's policy on sharps injuries.

The practice undertook clinical audits and clinical meetings included discussions regarding clinical audits but we did not see evidence of a planned programme of clinical audit being systematically used to improve outcomes for patients. We noted that the practice's weekly clinical meetings included discussion about performance, quality and risk. We were also told that quarterly group wide clinical governance meetings discussed significant events, risk management and complaints; and benchmarked the practice's QOF performance against similar practices within the Hurley Group.

Leadership, openness and transparency

Records showed that monthly team meetings took place and we saw that leadership issues such as senior staff

changes were communicated. We noted that a member of the senior management team was based at the practice and staff told us that there was an open culture at the practice and that they felt valued and supported.

The service was transparent, collaborative and open about performance. Records showed that QOF performance was regularly reviewed and action plans developed as appropriate. A quarterly staff newsletter included information such as organisational changes and significant events. We also saw that significant events reporting was used to provide positive feedback to staff. This report highlights possible risks at locations and is used to determine inspection frequency. Records showed that the practice had diarised a meeting to discuss the report and any implications for patient safety.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice's latest annual patient survey identified difficulties in making an appointment and we saw how the practice had acted on this feedback and changed the way in which the service was delivered.

The practice had an active patient participation group (PPG) and was also able to demonstrate how it had acted on the group's views.

The practice sought and received staff feedback at monthly team meetings and there was evidence that staff members' views were sought and acted upon. Staff told us they felt informed and that they were involved in decision making.

The practice had a whistleblowing policy which was electronically available to all staff on practice computers.

Management lead through learning & improvement

We saw evidence of how the practice supported staff to maintain their clinical professional development through training and mentoring. For example, the nurse practitioner had been allowed study time and was shortly to complete a post graduate clinical qualification.

There was also a strong focus on continuous learning and improvement at all levels of the organisation. Staff spoke positively about how the practice's involvement in a local network of four practices had improved clinical knowledge in areas such as infection and prevention control. We also

Are services well-led?

Good 

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

noted that learning from significant events was shared throughout the Hurley Group's 26 general practices so as to maximise improved patient outcomes. We looked at one

staff file and saw that annual appraisals took place which included a review of performance, objectives setting and an identification of the training required to meet those targets.