St Bartholomews Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Bartholomew's Surgery on 20 June 2016. Overall the practice is rated as requires improvement.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Not all safety systems and processes were in place such as fire safety, health and safety, medicines management and arrangements for the event of a medical emergency.
- Systems to assess, monitor and improve safety were not effective for example infection control, monitoring use of prescriptions and cleaning of premises and equipment.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had been trained to provide them with the knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services was not always easy to understand and improvements were not made to the quality of care as a result of complaints and concerns.
- The majority of patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

The areas where the provider must make improvements are:

- Arrange to assess, monitor, manage and mitigate risks to the health and safety of service users including health and safety, fire safety and COSHH.
- Ensure safe and effective management of medicines and prescriptions and for the event of a medical emergency.
- Improve and evaluate systems or policies to improve quality and safety such as complaints and completed audits or other clinical quality improvement activity.

In addition the provider should:

- Ensure all necessary information is held in the business continuity plan.
- Seek to improve the uptake of patients attending for cervical screening.
- Review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Review arrangements to support patients who are deaf or hard of hearing, and whose first language is not English.
- Implement effective arrangements for meetings documentation and actions follow up.

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?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. The practice did not have a significant events policy but had documented and managed significant events effectively.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Several systems and processes arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were absent or ineffective such as safe medicines management and COSHH.
- Not all risks to patients were assessed and well managed. For example there was no risk assessment for health and safety or fire safety, or record of premises and equipment cleaning.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safeguarded from abuse.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- The practice had limited assessment of patient outcomes and had not carried out any clinical audits and re-audits to improve patient outcomes.
- Multidisciplinary meetings were not taking place but such meetings were due to restart and had been a challenge in local area, rather than specific to the individual practice.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the national average, with the exception of uptake for the cervical screening programme that was 69% and below both the CCG average of 81% and the national average of 82%.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the knowledge and experience to deliver effective care and treatment.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the as comparable to others all aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 1% of its list as carers. It did not have local arrangements to support carers but written information was available in the reception area to direct carers to the various avenues of support available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff or used to improve services.
- The practice did not advertise translation services for patients whose first language is not English and there was no hearing loop for patients who were deaf or hard of hearing.
- Practice staff reviewed the needs of its local population and provided a weekly walk in family planning clinic every Monday 6:00pm to 6.30pm.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice had a vision to deliver quality care and good outcomes.

Summary of findings

- Several systems and processes arrangements for identifying, recording and managing risks were absent or ineffective and staff told us the practice was in transition and in the process of improving.
- There was a clear leadership structure and staff felt supported by management. Some systems and practice specific policies were available to staff and several updates were in train such as health and safety and infection control.
- There was an overarching governance framework but staff meetings notes did not demonstrate effective systems for follow up or completion of actions.
- The practice had not used benchmarking data or continuous clinical or internal audit to monitor quality and to make improvements.
- The practice did not have a significant events policy but had managed significant events effectively. The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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

Requires improvement

The provider was rated as requires improvement for safety, effectiveness and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The percentage of patients with rheumatoid arthritis, on the register, who had a face-to-face annual review in the preceding 12 months was 100% which was comparable to 91% within the CCG and 91% nationally.
- Multi-disciplinary team meetings were not taking place but this was CCG led and they were due to restart and care plans for frail older people were routinely reviewed and updated.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safety, effectiveness and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was 88% which is similar to CCG and national averages (CCG average 87%, national average of 89%)
- The percentage of patients with hypertension having regular blood pressure tests was 86%, which is similar to the CCG and national averages of 84%
- Longer appointments and home visits were available when needed.
- Patients had a named GP and a structured annual review to check their health and medicines needs were being met.
- Multi-disciplinary team meetings were not taking place but this was CCG led and they were due to restart. Care plans were routinely reviewed and updated.

Summary of findings

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safety, effectiveness and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- Childhood immunisation rates for the vaccines given to under two year olds ranged from 80% to 94% (CCG ranged from 82% to 94%) and five year olds from 76% to 94% (CCG also ranged from 82% to 95%).
- The practice provided weekly walk in family planning clinics.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 69%, which was below the CCG average of 81% and the national average of 82%. Staff told us members of their female community were from religious and ethnic groups that tended to decline cervical screening tests.
- Appointments were available outside of school hours and the premises were suitable for children and babies, and we saw positive examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safety, effectiveness and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Patients aged 40–74 had access to appropriate health assessments and checks that were followed up where abnormalities or risk factors were identified.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement 

The provider was rated as requires improvement for safety, effectiveness and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- The practice held a register of patients living in vulnerable circumstances including those with learning disabilities.
- The practice offered longer appointments for patients with a learning disability and identified 17 patients on its list, all 17 (100%) had received an annual health check in 2015 – 2016.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The provider was rated as requires improvement for safety, effectiveness and well-led. The issues identified as requiring improvement overall affected all patients including this population group. There were, however, examples of good practice:

- 95% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months compared to the CCG average of 87% and the national average of 84%.
- The practice carried out advance care planning for patients with dementia.
- Performance for mental health related indicators was 100% compared to the CCG average at 87% and the national average of 93%, the practice had identified 82 patients on its register with a mental health condition requiring an annual health check and 86% of these patients had received the check.
- Multi-disciplinary team meetings were not taking place but we saw evidence staff were working with allied mental health professionals in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. Three hundred and ninety eight forms were distributed and one hundred and fourteen were returned. This represented 1% of the practice's patient list.

- 68% found it easy to get through to this surgery by phone which was comparable to the CCG average of 61% and the national average of 73%.
- 82% were able to get an appointment to see or speak to someone the last time they tried (CCG average 76%, national average 85%).
- 88% described the overall experience of their GP surgery as fairly good or very good which was comparable to the CCG average of 76% and the national average of 85%.
- 83% said they would recommend their GP surgery to someone who has just moved to the local area which was higher than the CCG average of 66%, and comparable to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards, 30 of which were positive about the standard of care received. Patients said staff were helpful, friendly and caring.

We spoke with 11 patients during the inspection. Ten of the 11 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The practice friends and family survey test results showed 76% of patients would recommend the surgery, which was in the middle range.

Areas for improvement

Action the service MUST take to improve

- Arrange to assess, monitor, manage and mitigate risks to the health and safety of service users including health and safety, fire safety and COSHH.
- Ensure safe and effective management of medicines and prescriptions and for the event of a medical emergency.
- Improve and evaluate systems or policies to improve quality and safety such as complaints and completed audits or other clinical quality improvement activity.

Action the service SHOULD take to improve

- Ensure all necessary information is held in the business continuity plan.
- Seek to improve the uptake of patients attending for cervical screening.
- Review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Review arrangements to support patients who are deaf or hard of hearing, and whose first language is not English.
- Implement effective arrangements for meetings documentation and actions follow up.

St Bartholomews Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The team included a GP specialist adviser, a practice nurse specialist adviser, a practice manager specialist adviser and an Expert by Experience.

Background to St Bartholomews Surgery

St Bartholomew's Surgery is situated within NHS Newham Clinical Commissioning Group (CCG). The practice provides services to approximately 10,200 patients under a Personal Medical Services (PMS) contract. The practice provides a full range of enhanced services including a diabetes clinic health checks, child and travel vaccines including Yellow Fever and Family Planning (including coil fitting). It is registered with the Care Quality Commission to carry on the regulated activities of maternity and midwifery services, family planning services, treatment of disease, disorder or injury, surgical procedures, and diagnostic and screening procedures.

The staff team at the practice includes five GP partners, one female working eight sessions per week and four male (two working eight sessions, one working seven sessions and one working four sessions per week), two female practice nurses both working eight sessions per week, two female healthcare assistants (one working 14 hours and the other ten hours per week). There is a newly recruited full time practice manager working 37.5 hours per week and a team of reception and administrative staff all working a mixture of full time and part time hours. The practice told us it was in a transitionary period following the retirement of a partner GP and recruitment of staff including management and clinical staff.

The practices core opening hours are between 8:00am to 6.30pm every weekday. GP appointments are from 8:30am to 12.00pm and 3.00pm to 6.30pm. Appointments are from 8.00am until 5.00pm on Mondays and Thursdays and from 8.00am until 6.00pm on Tuesdays, Wednesdays and Fridays. The practice offers on site extended hours GP appointments from 6.30pm until 8.30pm on Mondays. Off-site extended hours through a network of local practices every weekday until 9.30pm, every Saturday from 9am until 6.00pm and every Sunday from 9.00am to 1.00pm. Patients telephoning when the practice is closed are transferred automatically to the local Newham GP Co-op out-of-hours service provider. Appointments include pre-bookable appointments, home visits, telephone consultations and urgent appointments for patients who need them.

The practice is located in one of the most diverse and deprived areas in England and has a relatively young population. Data showed 9% of its patients are aged over 65 years compared to 6% within the CCG and 17% nationally. The average male and female life expectancy for the practice is 79 years for males (compared to 77 years within the CCG and 79 years nationally), and 84 years for females (compared to 82 years within the CCG and 83 years nationally). Data held locally at the practice showed 64% of its patients are from black and ethnic minority communities.

The practice was inspected on 5 August 2014 under the previous regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and was not

compliant under parts of Regulation 12 Cleanliness and infection control and Regulation 21 Requirements relating to workers. A link to the report is here http://www.cqc.org.uk/location/1-539009738

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected under the current regulations.

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 June 2016.

During our visit we:

- Spoke with a range of staff (GP partners, a practice nurse, practice manager, health care assistant, and reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The practice did not have a significant events policy but had reported, recorded and learned from significant events to improve safety.

Staff told us they would inform the practice manager of any incidents and there was a recording book and analysis form available that supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records and incident reports and saw that lessons were shared and action was taken to improve safety in the practice. For example, the practice found a delay in linking patients test results to their diagnosis. It arranged for a GP to attend specialist training and changed its protocol for reviewing patients test results to confirm completion of required actions.

Overview of safety systems and processes

The practice had defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse but other safety systems had weaknesses:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding both adults and children. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3 and practice nurses were trained to level 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained some standards of cleanliness and hygiene and we observed the premises to be clean and tidy. Annual infection control audits were undertaken and actions action had been taken to address any improvements identified as a result. Staff had received up to date infection control training but the practice did not have a nominated infection control clinical lead and there was no documentary evidence of clinical equipment cleaning, although it was visibly clean. The spirometer (an instrument for measuring the air capacity of the lungs) mouthpiece and other medical equipment were sterile, single use and disposable. The schedule for cleaning the premises was not completed for example to indicate daily cleaning of the toilets and wash hand basins. Cleaning equipment was well used and stored in damp conditions in an unventilated room and there were no replacements available. We asked to see the infection control policy that was held on the practice system and it was incomplete.
- Not all arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). We found a box of influenza vaccines had expired in May 2016 which the practice disposed of immediately. All remaining vaccines had been correctly stored but there was only one medicines refrigerator thermometer (two are recommended).
- Processes were in place for handling repeat prescriptions including reviewing of high risk medicines. The practice carried out regular medicines audits with the support of the local CCG pharmacy teams to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored; however, there were no systems in

place to monitor their use. Some Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation and Health Care Assistants were trained to administer vaccines and medicines. However, there was no PGD or patient specific prescription or direction from a prescriber for practice nurses administering yellow fever vaccines or PGD for pertussis (whooping cough). Patient specific directions for health care assistants administering influenza vaccines were signed by GPs after administration rather than before as required.

- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Not all risks to patients were assessed and well managed.

- There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives but the practice did not have risk assessments for health and safety, fire safety, or control of substances hazardous to health (COSHH). The practice had carried out a Legionella risk assessment in 2015 and actions were followed up except those of low risk (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice manager told us they were working through safety issues them in order of priority and we saw some operational plans were being delivered. For example, staff were trained in fire safety, regular drills were carried out and there were notices around the practice showing action in the event of a fire. Immediately after inspection the practice sent us its new comprehensive risk assessment toolkit that included areas such as fire safety, infection control and COSHH that had not yet been completed.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

- The practice had most arrangements in place to respond to emergencies and major incidents.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support and the practice had a defibrillator available on the premises and oxygen with adult masks, but no children's masks were available for emergency use. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely but there was no emergency use atropine (recommended for practices that fit coils/for patients with an abnormally slow heart rate) and the practice had not assessed the risk of having no atropine available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. However, the plan did not include emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice did not monitor that best practice guidelines were followed through.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available, with 6% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 1 April 2014 to 31 March 2015 showed the practice was an outlier for QOF clinical targets:

- The ratio of reported versus expected prevalence for Coronary Heart Disease (CHD) was 0.44 which was below 0.55 within the CCG and 0.71 nationally. However, the practice had a relatively young population which explained the deviation.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 69%, which was below the CCG average of 81% and the national average of 82%. We asked staff about the low result and they told us members of their female community were from religious and ethnic groups that tended to decline cervical screening tests. Staff told us they had tried information notes and leaflets to encourage patients to have the test, and by inviting them to take the opportunity of a smear during consultations with female clinicians and that this had not significant increased uptake for the test. The practices cervical screening exception reporting rates were 7%, compared to 11% in the CCG and 6% nationally.

The practice was not an outlier for any other QOF (or other national) clinical targets. Data from 2014 - 2015 showed;

- Performance for diabetes related indicators was 88% which is similar to CCG and national averages (CCG average 87%, national average of 89%)
- The percentage of patients with hypertension having regular blood pressure tests was 86%, which is similar to the CCG and national averages of 84%
- Performance for mental health related indicators was 100%, which was similar to CCG and national averages (CCG average 87%, national average 93%)

There was no evidence of quality improvement including clinical audit within the last two years.

- There had been one clinical audit completed in the last two years, but no second cycle had been undertaken to monitor and implement improvements.
- The practice participated in local audits but benchmarking was limited to local accident and emergency comparators.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions such as diabetes and Chronic Obstructive Pulmonary Disease (COPD).
- Staff and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff administering vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes and had been trained.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate

Requires improvement

Are services effective?

(for example, treatment is effective)

training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, clinical supervision and facilitation and support for revalidating GPs. Staff had received an appraisal within the last 12 months.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Multi-disciplinary team meetings were not taking place, the last being in June 2015 with documentation limited to an agenda and attendance list. However, care plans were routinely reviewed and updated and we subsequently found that implementing multi-disciplinary meetings had been a challenge in the local area, rather than specific to the individual practice and the CCG was implementing arrangements to restart multidisciplinary meetings in July 2016.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccines given were comparable to CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 80% to 94% (CCG ranged from 82% to 94%) and five year olds from 76% to 94% (CCG ranged from 82% to 95%).

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Thirty of the 31 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

Results from the national GP patient survey published January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was comparable for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%.
- 89% said the GP gave them enough time (CCG average 79%, national average 87%).
- 96% said they had confidence and trust in the last GP they saw (CCG average 91%, national average 95%).
- 84% said the last GP they spoke to was good at treating them with care and concern (CCG average 76%, national average 85%).
- 91% said the last nurse they spoke to was good at treating them with care and concern (CCG average 80%, national average 91%).
- 93% said they found the receptionists at the practice helpful (CCG average 80%, national average 87%).

Care planning and involvement in decisions about care and treatment

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

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

- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care (CCG average 74%, national average 82%).
- 92% said the last nurse they saw was good at involving them in decisions about their care (CCG average 77%, national average 85%).

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

- Staff told us that translation services were available for patients who did not have English as a first language. Translation services were not advertised in the reception area to inform patients the service was available; however we saw they been used when needed.
- Information leaflets were available in easy read format including in non-English languages.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 176 patients as

Good

Are services caring?

carers (1% of the practice list). The practice did not have local arrangements to support carers but written information was available in the reception area to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population; it had a high proportion of people of working age and unplanned pregnancies and provided a weekly walk in family planning clinic every Monday 6:00pm to 6.30pm.

- The practice offered on-site extended hours GP appointments from 6.30pm until 8.30pm on Mondays, and off-site extended hours every weekday until 9.30pm through a network of local practices for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately such as Yellow Fever.
- There were disabled facilities and translation services available however they were not clearly advertised.
- There was no hearing loop, however we saw that BSL translators had been booked and longer appointments provided for patients where needed.
- The practice was on the ground floor of a purpose built premises and was wheelchair accessible.

The practice had undertaken a patient's survey in March 2016 and used scores to plan and deliver improvements where patients had expressed less than 85% satisfaction. For example, it had deployed more staff to answer patient's telephone calls at peak times between 8.00am and 9.00am and GPs were focusing on keeping appointments to a maximum of ten minutes wherever possible to avoid appointments overrunning and patients being delayed.

Access to the service

The practices core opening hours were between 8:00am to 6.30pm every weekday. GP appointments were from 8:30am to 12.00pm and 3.00pm to 6.30pm. Appointments were from 8.00am until 5.00pm on Mondays and Thursdays and from 8.00am until 6.00pm on Tuesdays, Wednesdays and Fridays. The practice offered on site extended hours GP appointments from 6.30pm until 8.30pm on Mondays and off-site extended hours every weekday until 9.30pm, every Saturday from 9am until 6.00pm and every Sunday from 9.00am to 1.00pm through a network of local practices. Patients telephoning when the practice was closed were transferred automatically to the local Newham GP Co-op out-of-hours service provider. Appointments included pre-bookable appointments, home visits, telephone consultations and urgent appointments for patients who needed them.

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

- 93% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 78%.
- 69% of patients said they could get through easily to the practice by phone compared to the CCG average of 61% and national average of 73%.

Ten of the 11 patients we spoke to on the day of the inspection told us that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling individual complaints and concerns but there were no systems to inform wider practice improvements or analyse trends to improve the quality of care:

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible manager who handled all complaints in the practice.
- A complaints poster was displayed in the reception area to help patients understand the complaints system.

We looked at three complaints received in the last 12 months and found these were dealt with in a timely way and with openness when dealing with the complaint. For example, a patient complained about not being prescribed a particular medicine. Staff contacted the patient the same day and clinical staff followed up with a written explanation of why the medicine was not appropriate in that case. We checked another complaint where a patient had been

Good

Are services responsive to people's needs?

(for example, to feedback?)

unable to get a same day appointment for a family member. The practice called to hear the complainant directly and staff explained the appointment protocol which the complainant accepted.

Are services well-led?

Requires improvement

(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 vision to deliver quality care and good outcomes for patients, and was in the process of improving systems and processes.

- The practice had a mission statement, it was not displayed in the waiting areas but staff knew and understood the values.
- The practice told us it was in transition and we saw a development strategy and that is was in the process of implementing improvements.

Governance arrangements

The practice did not have an effective governance framework which supported the delivery of care:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Some systems and practice specific policies were available to all staff and several updates were underway such as health and safety and infection control.
- The practice was partially aware of its performance but benchmarking was limited and there was no continuous clinical or internal audit to monitor quality and make improvements.
- The practice had no system to use information from individual complaints or to analyse complaints trends to inform service improvement.
- The most recent documented staff meetings were in November 2015 and May 2016. Information contained in the notes was limited to attendees and agreement of agenda items at one of the meetings and systems to follow up or complete actions were not in place.
- Several arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were absent or ineffective such as safe medicines management and COSHH.

Leadership and culture

On the day of inspection the partners in the practice told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

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

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

- Staff told us the practice held weekly clinical meetings and quarterly whole team meetings and that all staff communicate openly and promptly on a day to day basis.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys. The PPG met regularly and submitted proposals for improvements to the practice management team.
- The practice had undertaken a patient's survey in March 2016 and used results to improve services, for example by providing greater staff cover to receive patient's telephone calls at their peak between 8.00am and 9.00am.
- The practice had gathered feedback from staff through staff meetings, appraisals, day to day discussion and

Are services well-led?

Requires improvement

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

social events. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and that they felt involved and engaged to improve how the practice was run.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users including health and safety, fire safety and COSHH. The provider did not ensure safe management of medicines including a lack of implementation of PGDs and PSDs, systems to ensure out of date medicines disposal, or comprehensive arrangements for in the event of a medical emergency. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Arrangements to assess, monitor and improve safety were absent or ineffective such as such as policies or systems for significant events, infection control, monitoring use of prescriptions, cleaning of premises and equipment. The provider did not adequately monitor and improve the quality of services. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.