Wordsworth Health Centre

Quality Report

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

Contents

Summary of findings

Overall summary

Wordsworth Health Centre, also known as The Graham Practice, is a general practice (GP) surgery that operates from a single premises located in Manor Park in the London borough of Newham. The equivalent of five full-time GPs work at the practice which has approximately 11,800 registered patients. Other healthcare professionals at the practice include practice nurses, health care assistants and a nurse consultant in cognitive behavioural therapy (CBT).

Census data shows an increasing population and a higher than average proportion of Black and minority ethnic residents in Newham. The proportion of people below 40 years of age is above the England average while the proportion of people above 40 years of age is below the England average. Newham is the second most deprived out of 326 local authorities. Drug misuse, recorded diabetes, incidence of TB and acute sexually transmitted infections are significantly worse than the England average. Life expectancy for males in Newham is below the England average. The number of early deaths due to cardiovascular disease is significantly worse than the England average.

As part of our inspection we asked other organisations, including NHS England, Newham Clinical Commissioning Group and Healthwatch Newham to share what they knew about the service with us. We also spoke to patients and invited them to leave their feedback for us on comments cards. We carried out an announced visit to the practice which lasted 1.25 days.

Patients we spoke with had confidence and trust in the treatment they received from the practice. They felt they were treated with care and respect by clinical staff and most reception staff. However they found it very difficult to see their GP and experienced the practice's GP telephone triage and consultation service as unresponsive to their needs. This was an area for improvement.

We found patients received services that were safe and well-led in many respects. The was a strong emphasis on clinical governance, which is a system for promoting excellence in the clinical care provided to patients, and there were systems in place to learn from significant events and from patient feedback, including complaints. Clinical and non-clinical staff were engaged and motivated to provide the best possible care to patients.

However, the practice was in breach of some regulations related to safety including:

- Fire safety
- Medicines management
- Cleanliness and infection control
- Requirements relating to workers

Other areas for improvement included:

- Patient information about the chaperone service.
- Feedback to patients about progress on the action plan from the 2013-2014 practice survey.
- Action plans for mitigating risk to the sustainability and effective operation of the practice.

We found patients received services that were effective and caring. The practice checked regularly that it was providing treatment and care in line with recognised best practice by completing clinical audit cycles. Staff received professional development to support them to deliver treatment and care to an appropriate standard. Patients felt involved in decisions about their care and consent procedures were in place to ensure patients understood the implications of their decisions.

We looked at services for:

- Older people
- People with long-term conditions
- Mothers, babies , children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

We found these population groups received care that was well-led, safe, effective and caring. Improvements were required to ensure the service was responsive and that all population groups could access the service.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Aspects of the safety of services patients receive required improvement.

There was a system in place for ensuring incidents were reported and investigated, and that the practice learned from incidents to improve the treatment and care provided. GP telephone triage was used to ensure patients were seen within a clinically appropriate period of time and appointments were set aside every day for patients who needed to be seen urgently. Patients were protected from the risks of unsafe or unsuitable equipment, and contingency plans were in place to avoid disruption in the service for patients, for example in the event of loss of utilities or incapacity of GPs.

Other safety systems were less well established. We found:

- Fire action notices had not been completed to include fire assembly point details, fire marshal details, and the contact details for emergency services. Fire doors were propped open and there were no notices to remind people not to use the lift in the event of a fire.
- There was no information for patients on display telling them about the availability of a chaperone.
- An anaphylaxis kit we looked at was two months past its expiry date and not fit for use.
- The temperature of one of the fridges in which medicines requiring cold storage were kept was not routinely checked and monitored to ensure these medicines were stored at the correct temperature at all times and fit for use.
- There were no formal infection control audits as part of the system for checking that all policies and procedures for preventing healthcare acquired infection were being adhered to within the practice.

The personnel records we looked at did not all contain all the information required for people appointed since the practice registered with the Care Quality Commission in April 2013 to demonstrate the practice appointed people who were of good character, had the necessary qualifications, skills and experience and were physically and mentally fit for their role.

Are services effective?

Patients received services that were effective. The practice checked that it was providing treatment and care in line with recognised best practice by completing clinical audit cycles. Staff received

Summary of findings

professional development to support them to deliver treatment and care to an appropriate standard. The practice was housed in suitable premises and was well equipped. The practice worked with other services to ensure patients received coordinated care and provided a range of health promotion and prevention interventions.

Are services caring?

Patients received services that were caring. Patients we spoke with felt they were treated with respect by clinical staff and that most reception staff were friendly and helpful. A few patients told us about staff going out of their way to help and support them. Patients felt involved in decisions about their care. Consent procedures were in place to ensure patients understood the implications of their decisions.

Are services responsive to people's needs?

The practice was working hard to be accessible to patients. The practice had introduced a telephone triage and consultation system to enable GPs to treat more patients every day because demand for appointments exceeded the availability of appointment slots. However, patients we spoke with experienced the new system as unresponsive to their needs.

The practice made provisions to meet the needs of all the population it served. It had use of interpreting services and took account of people's culture and faith. Disabled patients could access the service.

There was a system in place for responding to patients' complaints and concerns. The practice took complaints seriously and was agreeable to learning from complaints. The practice responded to complainants in an open and timely manner.

Are services well-led?

Patients received services that were well-led. There was a strong commitment to clinical governance within the practice, including clinical audit cycles, and the promotion of excellence in the clinical care provided to patients. Staff were engaged and motivated to provide the best possible care for patients.

There were systems in place to learn from significant events and patient feedback, including complaints, and the practice considered and responded to patient reviews left on the NHS choices website. There was no specific information available for patients about the progress the practice had made on the action plan to address areas for improvement identified in its 2013-2014 practice survey, however.

Summary of findings

The practice had a well-established Patient Reference Group (PRG). The practice consulted and involved the PRG in decisions about the operation of the service, for example the introduction of the GP telephone triage and consultation service.

The practice could not assure itself that actions to mitigate the risks to its sustainability and effective operation had been carried out and were effective.

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 service was safe, effective, caring and well-led for people aged 75 and over. Older patients we spoke with however did not experience the telephone triage and consultation as responsive to their needs. They did not always feel they were treated with dignity and respect when trying to make an appointment to see a GP.

Older patients told us they had confidence in the GPs, nurses and health care assistants. The practice completed clinical audit cycles to ensure it provided treatment that was safe and effective and worked with other services to ensure patients with complex needs received coordinated multidisciplinary care in their homes where possible. The practice had informed all patients aged over 75 who their named, accountable GP was.

People with long-term conditions
The service was safe, effective, caring, responsive and well-led for people with long term conditions.

Systems were in place to ensure patients received ongoing monitoring to keep them as well as possible and to prevent avoidable hospital admission. The practice completed clinical audit cycles and worked with specialists to ensure patients received treatment and care that was safe and effective, and tailored to their needs.

Mothers, babies, children and young people
The service was safe, effective, caring, responsive and well-led for mothers, babies, children and young people.

GPs and practice staff understood their role as part of the wider safeguarding community including health visitors and schools for example in protecting children from abuse. The practice worked with the midwifery service to provide joined up services to pregnant women and new mothers. It was meeting its target for childhood immunisations and preschool boosters. Babies and children were always prioritised for GP call backs. The practice was encouraging young people to have the chlamydia test.

The working-age population and those recently retired
The service was safe, effective, caring and well-led for people in this age group. However, some people did not experience the telephone triage and consultation system as responsive to their needs because it was difficult for them to use their phone while they were at work.

Summary of findings

The practice provided extended opening times to offer patients appointments to see their GP outside working hours. A system was in place to ensure people in this age group took up health promotion and prevention services available to them. The practice provided the full range of contraceptive choices.

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

The service was safe, effective, caring and well-led for people in vulnerable circumstances who may have poor access to primary care. However, concern was expressed by a few patients that people in vulnerable circumstances may not experience the telephone triage and consultation as responsive to their needs. We did not find any evidence to support this however.

GPs and practice staff understood their role as part of the wider safeguarding community including social services, for example, in protecting vulnerable people from abuse. Examples of the ways in which the practice supported access to primary care included understanding the need of people fleeing domestic violence to be reassured about confidentiality, and providing in-house substance misuse and phlebotomy services.

Patients with learning disabilities had annual health checks to help keep them as well as possible.

People experiencing poor mental health

The service was safe, effective, caring, responsive and well-led for people experiencing poor mental health.

The practice's cognitive behavioural therapy (CBT) nurse consultant provided flexible support to patients. Patients were also referred to the local psychological therapy service. GPs worked with specialists and other professionals to ensure patients with more complex needs received effective and coordinated care.

Summary of findings

What people who use the service say

We spoke with 23 patients and reviewed five comment cards.

Patients were positive about a range of the services provided at the practice, for example the support and flexibility provided by the psychological therapist and liaison with the midwifery service.

Patients felt they were treated with respect and care by clinical staff. For example one patient commented on the consideration and patience with which they had been treated because of their anxiety over having tests and injections.

Patients told us the GPs and other clinical staff were good. Patients had confidence in the doctors. Most patients told us reception staff were friendly and helpful, although a few told us reception staff were rude, or had been offhand and dismissive with them.

Many patients told us the appointment system could be improved. Some patients said it was difficult to get through to the surgery by phone and most patients said it was difficult to see a GP. A few said they had waited more than a week for a call back. Only one patient told us that they had not had any problem getting to see a GP. This was a new patient who said that the system for speaking to a doctor on the phone before any appointment was made to see a doctor had been explained to them clearly when they joined the practice. Some older patients we spoke with were particularly unhappy about losing face-to-face time with a doctor whom they felt knew them well.

Most patients felt involved in decisions about their treatment and said the doctors had explained everything to them well. They said they felt able to raise concerns or to give feedback about the practice to their doctor or to reception staff or the office manager. A few patients told us they did not know how to make a formal complaint.

Areas for improvement

Action the service MUST take to improve

- Fire action notices had not been completed to include fire assembly point details, fire marshal details, and the contact details for emergency services. Fire doors were propped open and there were no notices to remind people not to use the lift in the event of a fire.
- An anaphylaxis kit we looked at was two months past its expiry date and not fit for use.
- The temperature of one of the fridges in which medicines requiring cold storage were kept was not routinely checked and monitored to ensure these medicines were stored at the correct temperature at all times and fit for use.
- There were no formal infection control audits as part of the system for checking that all systems for preventing healthcare acquired infection were being adhered to within the practice.
- The personnel records we looked at did not all contain all the information required for people appointed since the practice registered with the Care Quality Commission in April 2013 to demonstrate the practice appointed people who were of good character; had the necessary qualifications, skills and experience and were physically and mentally fit for their role.

Action the service SHOULD take to improve

- There was no information for patients on display telling them about the availability of a chaperone.
- Many patients experienced the telephone triage and consultation service to be unresponsive to their needs.
- There was no specific information for patients about the progress the practice had made on its action plan to address areas for improvement that had been identified in the 2013-2014 practice survey.
- The practice could not assure itself that action to mitigate risks to its sustainability and effective operation had been carried out and was effective.

Wordsworth Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a second CQC inspector, the Head of Governance of an out-of-hours primary medical services provider, and an Expert by Experience from The Challenging Behaviour Foundation.

Background to Wordsworth Health Centre

Wordsworth Health Centre, also known as The Graham Practice, is located in Manor Park in the London borough of Newham. The practice is in purpose-built premises especially designed for general practice.

Census data shows an increasing population and a higher than average proportion of black and minority ethnic residents in Newham. The proportion of people below 40 years of age is above the England average while the proportion of people above 40 years of age is below the England average. Newham is the second most deprived out of 326 local authorities. Drug misuse, recorded diabetes, incidence of TB and acute sexually transmitted infections are significantly worse than the England average. Life expectancy for males in Newham is below the England average. The number of early deaths due to cardiovascular disease is significantly worse than the England average.

Wordsworth Health Centre is a member of the Newham Clinical Commissioning Group (CCG). The CCG is responsible for commissioning health services on behalf of the population of Newham and is led by a governing body on behalf of the 61 member GP practices. One of the GPs at Wordsworth Health Centre is a member of the governing body.

Wordsworth Health Centre is provided by a partnership of three GPs. It has approximately 11,800 registered patients. The equivalent of five full-time GPs work at the practice together with the equivalent on 1.5 full-time practice nurses and 1.8 full-time health care assistants. There are three male and three female GPs. Additional health care staff include a nurse consultant in cognitive behavioural therapy (CBT). There is a practice manager, operations manager, office manager, a patient participation and complaints manager, a team of administration and reception staff and a caretaker.

The service is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease, disorder or injury.

The practice has opted out of providing out-of-hours services to its patients. Out-of-hours services are provided by Newham GP Co-operative.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice, including NHS Quality and Outcomes Framework (QOF) data. We asked other organisations, including NHS England, Newham Clinical Commissioning Group and Healthwatch Newham to share what they knew about the service. We carried out an announced visit on 04 and 05 August 2014. During our visits we spoke with a range of staff including GPs, practice nurse and health care assistant staff, reception and administration staff, the practice manager, the operations manager and the patient participation and complaints manager. We looked at the documents the practice could show us about how they run the service.

We spoke with the chair of the Patient Reference Group and with patients who used the service and their carers and/or family members. We observed how people were being cared for and spoken to by GPs and staff working at the practice. We reviewed comment cards where patients and members of the public shared with us their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used information from multiple sources to maintain an overview and improve the safety of the service it provided. Information from complaints, safeguarding, significant events, and clinical audit was discussed at monthly clinical governance (CG) meetings, where actions to improve the safety of the service were agreed. CG meetings were attended by GPs, managers and representatives of the healthcare assistants and practice nurses and reception teams to ensure all staff were involved in highlighting and mitigating risks to patient safety. Staff we spoke with told us they felt listened to and that their views and suggestions for improving the service were taken seriously. The practice had a whistleblowing policy to support staff to act on any suspected wrongdoing at work.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff were aware of the procedure for reporting significant events and of the practice's designated leads for responding to clinical and non-clinical significant events. The practice's log of significant events showed that learning points from each event had been identified and changes made to the practice's systems and processes where required to prevent reoccurrence. For example, the practice had improved its system for tracking urgent referrals for suspected cancer after an incident in which a patient was not seen by the hospital within two weeks. The forms staff used were corrected and improved, more information was included in the log so that referrals and appointments were tracked more closely, and there was a named member of staff who took over the task. The practice also rechecked that all other patients had received an appointment.

Reliable safety systems and processes including safeguarding

Systems and processes were in place to minimise the potential for error around prescriptions and repeat prescriptions. Staff producing the prescriptions for GPs to sign worked away from the reception area where they would not be disturbed. The computer system alerted staff to when medication and other reviews were due and the practice had developed a system for sending reminders to patients about their reviews, along with their prescription, to help patients manage their condition.

GPs and staff employed by the practice were up-to-date with child protection and safeguarding adults training. The GPs, practice nurses and health care assistants had completed Level 3 child protection training in line with their closer involvement with patients. All other staff had completed Level 1. The practice had a lead GPs for child protection and for safeguarding adults to oversee implementation of the practice's safeguarding policies and procedures. Staff were aware of the signs of possible abuse or neglect and knew how to act on any concerns they had to protect patients from harm. GP registrars were also aware of the local procedures for acting on child protection and safeguarding concerns. Information about safeguarding issues and concerns was shared at the monthly clinical governance meetings.

GPs and staff we spoke with told us staff were on hand to be present during a face-to-face consultation if the patient or GP required a chaperone. A chaperone is a third party present at a consultation that involves an intimate examination as a safeguard for all parties. All staff who might act as a chaperone had been Disclosure and Barring Service (DBS) checked as part of checks to ensure they were suitable for the role. There was no information for patients on display telling them about the availability of a chaperone, however, to ensure all patients were aware of this additional safeguard that they could request.

Patient records were kept securely and staff had completed training in information governance to ensure they understood the rules about patient confidentiality.

The practice was housed in purpose-built premises. The premises were in a good state of repair. The practice had a budget for the routine maintenance of the premises and repairs. Health and Safety law information for employees was on display in a format approved by the Health and Safety Executive (HSE). Staff were due health and safety training and a training course had been scheduled to take place in September 2014.

The practice must improve its fire safety arrangements. Fire action notices we saw had not been completed to include fire assembly point details, fire marshal details, and the

contact details for emergency services. Fire doors were propped open, and there were no notices to remind people not to use the lift in the event of a fire. Annual servicing of fire extinguishers had been completed in February 2014.

Monitoring safety and responding to risk

The practice set aside a number of emergency appointments for each GP each day in order to respond to patients who needed to be seen urgently. The practice also operated GP telephone triage to ensure patients were seen within a clinically appropriate period of time. Arrangements were in place for patients who needed to be seen by a GP when the practice was closed.

Reception staff were deployed so that there were more staff on duty when there was greater demand on the service, for example over the lunchtime period when people were more likely to call in to the practice.

Arrangements were in place to secure cover when GPs and practice nurses were on planned leave or attending training. There was a clear and comprehensive induction programme in place, including a locum pack, to help new and locum staff familiarise themselves quickly with the practice's systems and processes.

Clinical and non-clinical staff had completed basic life support refresher training in 2014. Emergency equipment including an automated external defibrillator and oxygen gas cylinder was checked regularly to ensure it was fit for use at all times.

Medicines management

Staff were able to describe to us the system for ensuring the practice maintained adequate stocks of the medicines it used regularly to treat patients and of medicines required to treat medical emergencies. However, the anaphylaxis kit we looked at was two months past its expiry date and not fit for use. Medicines requiring cold storage were kept in two fridges. The temperature of one of the fridges was not being routinely checked and monitored to ensure medicines kept in this fridge were being stored at the correct temperature at all times and so fit for use. There were no locks on the fridges to prevent medicine being tampered with, however the fridges were kept in a lockable room.

Prescription forms were kept securely to prevent them being stolen or misused. A log book system ensured all forms used for prescribing controlled drugs were accounted for.

The practice worked with the Clinical Commissioning Group (CCG) pharmacy advisor to ensure medicines were used to achieve the best outcomes for patients. For example, the practice was involved in a piece of work to evaluate and improve antibiotic prescribing in all GP practices in Newham. It was too early to evaluate the impact of the audit on prescribing practice at Wordsworth Health Centre.

The practice also undertook its own checks to ensure it was prescribing medicines safely. For example it had completed an audit of its practice against national guidelines for monitoring patients on disease-modifying anti-rheumatic drugs (DMARDs), which have potentially serious side-effects. This showed patients were having regular blood tests to reduce the incidence of side effects.

Cleanliness and infection control

The practice must improve its systems for ensuring all policies and procedures for preventing healthcare acquired infection were being adhered to. The practice was visibly clean. There were appropriate facilities for hand-washing and for dealing with clinical waste. Personal protective equipment for example disposable gloves and adequate supplies of single use items were available to prevent cross infection. Domestic cleaning equipment, for example mops and buckets were colour-coded to prevent cross-contamination. There were infection prevention and control policies and procedures in place to provide guidance to staff and staff had received infection control training. The practice had a designated infection control lead who told us they completed regular checks, for example that consulting rooms were clean and that clinical waste was being disposed of appropriately. However, there had been no formal infection control audits within the last 12 months to ensure systematically that all infection prevention and control policies and procedures were being adhered to.

Staffing and recruitment

The practice must improve the information it is able to make available in respect of the staff it employs. The personnel records did not all contain all of the information required for staff appointed since the practice registered with the Care Quality Commission in April 2013. Such information includes for example photographic proof of identity, a Disclosure and Barring Service (DBS) check

where appropriate, and evidence of conduct in previous employment to demonstrate that employees are of good character, have the necessary qualifications, skills and experience and are physically and mentally fit for their role.

Dealing with emergencies

The practice's business continuity plan set out the alternative arrangements to be put in place so that there would be no disruption in the service for patients, for example in the event of loss of utilities or incapacity of GPs.

Equipment

The practice had contracts in place for the maintenance, repair, safety testing and routine recalibration of its medical and electrical equipment to ensure it was fit for use at all times.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment in line with standards

The practice had a designated clinical governance (CG) lead GP who had protected time each week to carry out their role. Part of their role was to keep under review the quality of clinical services provided at the practice and to effect improvements to reception, GP, nursing and management protocols in response to new National Institute for Health and Care Excellence (NICE) and local evidence based guidance, safety alerts, significant event investigations, and commissioning agreements. The monthly clinical governance meeting was managed by the CG lead and provided the forum for this work in the practice. Minutes of the meetings held in March to June 2014 showed they were well attended and dealt effectively with clinical governance matters.

Clinical staff we spoke with had knowledge of the Mental Capacity Act (2005) and were aware they may need to assess mental capacity to make some decisions when treating patients with learning disabilities and dementia, for example.

Management, monitoring and improving outcomes for people

Respondents to the national patient survey in 2013 had confidence and trust in the last GP they had seen or spoken to.

The practice had a system in place for completing clinical audit cycles. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. Clinical audit cycles included, for example, the adequacy of cervical cytology smears to improve the rate of smears reported as 'inadequate', antibiotic prescribing, referral rates, the additional management of patients with raised erythrocyte sedimentation rates (ESR), which is a blood test and new cancer diagnoses over the previous 12 months. The audit cycles had checked the practice's performance against agreed guidelines and best practice, for example NICE guidance, then agreed ways of improving performance where required, and had scheduled when performance would be checked again to see that improvements had been made. Most of the follow up audits were scheduled for later in 2014; however three of the 13 follow up audits were overdue. The practice had designed high quality audits that would provide it with robust information about its outcomes.

The practice had effective call and recall systems for patients with conditions identified on the Quality and Outcomes Framework (QOF) register, for example patients with long term conditions. QOF is a voluntary annual reward and incentive programme to remunerate general practice for providing good quality care to their patients.

Effective staffing, equipment and facilities

Arrangements were in place to support the GPs' continuing professional development, appraisal and revalidation. The GPs were up to date with revalidation.

GPs were given protected time for their additional roles, For example the clinical governance GP lead had one morning set aside a week for this work. This time was used to promote clinical governance activity within the practice and manage the monthly clinical governance meetings.

The Wordsworth Health Centre is a training practice. The GP registrars we spoke with were positive about the training and support provided by the practice. Some of the GP partners had completed their specialist training as a GP at the practice.

There was a locum pack to ensure locum GPs were able to take up their responsibilities quickly and effectively. The practice used the same locum staff as much as possible. Consultations by locums were checked by the clinical governance lead to ensure local protocols were being followed, for example around prescribing.

Arrangements were in place to support and develop staff. There were regular clinical meetings that provided clinical supervision and support to the practice nurses and health care assistants.

Staff felt well supported by the practice and that the GPs, their supervisors and the practice manager were approachable and listened to them. They told us there were regular management, team and practice meetings to involve GPs and staff in the efficient and successful running of the service. Each team, for example the administration and reception staff team was represented at the monthly clinical governance meetings to ensure everyone was involved in the operation of a clinically safe and effective service.

Are services effective?

(for example, treatment is effective)

There was a system of yearly appraisals in place for staff employed by the practice, including practice nurses and health care assistants. Appraisals were used to support and engage staff in developing the service and meeting key performance indicators, for example targets for childhood immunisations and smear tests. The practice was also using the appraisal system to help staff realise their ambitions to develop new skills and gain new qualifications while increasing the skills mix within the practice team. For example, a senior receptionist had been trained to take blood samples and to complete some health checks as part of diabetic patients' annual reviews.

Staff received refresher training in core areas such as safeguarding, basic life support, health and safety, infection control and information governance to keep their knowledge and skills up to date. Staff also received training to meet specific needs of the practice's patients, for example people with learning disabilities and an update on diabetes. Staff told us they were encouraged to look for training courses that interested them and were relevant to their role, which motivated them and helped them enjoy working for the practice.

The practice had contracts in place for the maintenance, repair, safety-testing and annual recalibration of its medical equipment to ensure it was fit for use. The facilities and equipment in use reflected best practice and had a positive impact on patient outcomes.

Working with other services

The practice worked with the locality extended primary care team to review the treatment of patients with complex needs. The team included the community psychiatric nurse and palliative care nurse and met once a month.

The practice also had regular meetings with the community diabetes specialist nurse to ensure diabetic patients received high quality treatment and care.

The practice worked with the virtual ward which treated and supported patients in their own homes who were at risk of hospital admission, for example patients who needed rehabilitation after a fall or patients at the end of their lives. The virtual ward included community nursing, specialist therapies, community psychiatric nursing, and social services.

The practice received timely information from its out-of-hours (OOH) provider. All information coming into the practice from the OOH service was reviewed by a GP to ensure patients who had used the service experienced continuity in their clinical care. The practice also shared information with the OOH provider to ensure patients received care appropriate to their needs, for example patients with long-term conditions or with an end-of-life care plan in place.

Health promotion and prevention

All new patients to the practice were offered a new patient check. This ensured the practice had up-to-date information about the person's medical history, medication, and any outstanding health checks or immunisations.

The practice was meeting its targets for recording the smoking status of patients on its coronary heart disease (CHD) register and for offering these patients advice and/or referral for smoking cessation. Health care assistants ran smoking cessation clinics at the practice which improved patients' access to this service. We were unable to assess the impact of these measures on helping people to stop smoking.

Health care assistants also provided dietary and physical activity education and advice as part of the practice's pre-diabetes service. The practice had a plan in place to achieve its target for completing annual reviews of patients on its pre-diabetes register.

Patients were sign-posted to talking therapy, cognitive behavioural therapy, and physiotherapy services available at the practice. Patients could refer themselves to these services.

A range of patient information was available including diabetes, drugs, smoking, TB, men's health, family planning, and sexual health services for young people. Culturally responsive information was also on display, for example advice for diabetic patients about fasting during Ramadan and about the health effects of shisha smoking which is traditionally used by people from Middle Eastern or Asian community groups to smoke tobacco.

The practice was putting together a register of carers to help it deliver services that meet carers' needs. When new patients registered with the practice they were asked if they were a carer or had a carer. The practice had a protocol in place to identify when a carer should have a separate carer's assessment. The protocol also included signposting information so that staff could give advice and support to carers.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Respondents to the national patient survey in 2013 said the last GP they had seen or spoken to had been good at treating them with care and concern.

We observed reception staff being helpful, cheerful and courteous in their dealings with patients. We also observed two occasions when patients were swearing loudly at reception staff who remained calm, quiet and polite.

Patients we spoke with gave us examples of the service being caring and compassionate. For example one patient we spoke with was very appreciative of the practice dropping prescriptions off for them at their home.

Patients could speak in confidence with reception staff in an area away from the reception desk if they requested this.

More vulnerable patients and patients with complex needs each had a named clinician to act as a point of contact and improve the continuity of the care these patients received.

Involvement in decisions and consent

Sixty-nine percent of respondents to the national patient survey in 2013 said the last GP they had seen or spoken to had been good at involving them in decisions about their care, broadly in line with the average for the region. Four hundred and fifty-five surveys were sent out and one hundred and forty surveys were returned, a completion rate of 31%.

There were procedures in place for gaining consent from patients for different kinds of procedures and interventions, and for gaining consent from patients who were children or young people, or who lacked capacity to make some decisions.

The practice liaised and shared information with the community palliative care nurse and its out-of-hours service provider to ensure the decisions of patients with end-of-life care plans were respected.

There was a procedure in place for allowing patients to give their consent for the practice to discuss their details with a recorded carer, for example their daughter or son. Reception staff checked whether or not this consent was in place before giving out details of a patient's care to a third party.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice sought to meet the needs of the diverse population it served. The practice had use of a telephone interpreting service and could book interpreters for patient appointments. However, patients mostly brought a family member with them to act as an interpreter when they needed one.

There was a hearing loop for patients using a hearing aid and the practice was accessible to wheelchair users. There was a car parking space for disabled patients.

The practice had its own website which provided information for patients about services at the practice and how the practice worked. However, none of this information was readily available in any community languages despite the high proportion of people living in Newham for whom English was an additional language.

The practice had an established Patient Reference Group (PRG). The PRG was supported by a dedicated patient participation and complaints manager and written notes were kept of its meetings. The practice manager attended the meetings to respond to and to take forward the PRG's feedback and suggestions, for example about improving the facility for booking for a GP call back online.

Access to the service

The practice saw access to the service as its biggest challenge. The practice performed poorly in the national GP patient survey in 2013 compared with other practices when patients were asked about getting through to the surgery by phone and getting to see or speak to a preferred GP. Only 48% of respondents described their experience of making an appointment as good, compared to the Newham average of 66%.

In response to this feedback the practice had introduced a new appointment system where instead of a patient phoning the practice and having a receptionist book an appointment, the receptionist asked the patient a few questions and then passed the request to the GP. Reception staff had been trained in the new system. The GP would then call the patient back and provide advice and treatment, for example a prescription, over the phone; or they would make an appointment to see the patient if needed. Some requests, for example for sick notes and tests results were handled by other members of the clinical team. Patients could also visit the practice to arrange a call back from the GP.

The practice was able to identify a number of benefits of the new system. GPs were able to provide care and treatment to more patients each session and patients received care and treatment depending on the urgency of their clinical need. The new system was fairer for patients who were less able than other patients to be first in line on the phones or at the front door. The practice had also found that the number of wasted appointments, when patients had not attended their appointment had been significantly reduced.

The practice had increased the length of some appointments, for example for patients having asthma reviews, to ensure there was enough time to get everything done.

However, patients were not happy with the new appointment system. The practice had received a petition from patients against the new system, and only one of the 23 patients we spoke with during our inspection said it was easy to get an appointment. A few patients told us the phones were always engaged or it took a long time for staff to answer the phone. A few patients told us they had waited more than a week for the GP to ring them back. We also heard advice being given poorly by reception staff to patients who called the practice after all the day's 50 routine GP call backs had been booked. For example, patients were advised inappropriately to go to A&E or to phone back after 6.30pm when their call would be picked up by the out-of-hours service as an alternative to phoning the practice again the following day. Going to A&E or using the out-of-hours service would be appropriate if the patient's condition deteriorated so that they needed treatment and care out-of-hours, or as an emergency.

The practice was meeting with the person who had organised the petition to look at ways of improving the system, and was continuing to monitor the effectiveness of the system and to work with the Patient Reference Group to develop ways of helping patients to understand better how telephone triage and consultation worked and how to get the best out of the new system.

Protocols were in place to guide reception staff, for example when to ensure a patient was called back by a GP

Are services responsive to people's needs?

(for example, to feedback?)

urgently and when to refer call backs to other members of the clinical team. For example, test results could be given to patients by the health care assistant. We also found reception staff gave patients advice about what to do if their condition deteriorated and they had not yet heard back from the practice. Reception staff told us they had received customer service training that they had found useful when speaking with callers who were not used to the new appointment system and were not happy with it. Reception staff told us they were getting support from their supervisors and managers. The practice had designated a lead GP for access who was also involved in training and supporting reception staff, reviewing and responding to patients' complaints, and making improvements to the telephone triage and consultation system.

The practice had facilities for ordering or viewing repeat prescriptions and appointment booking online for the convenience of patients.

Meeting people's needs

The practice took account of people's culture and faith. For example, there were arrangements in place to ensure an expected death that occurred out of hours was certified by a GP within 24 hours to support bereaved families' burial practices. Islam and Judaism require the prompt burial of the deceased, for example. The practice also wrote to bereaved families to offer condolences and support, including referral to psychological services where needed.

The practice had developed awareness of issues affecting members of its practice population. For example, staff were knowledgeable about female genital mutilation (FGM) and the guidelines for the protection of girls at risk of FGM. They had also developed awareness of meeting the needs of people fleeing domestic violence.

Patients could choose to see a male, female or named GP where this preference could be met within a clinically appropriate timeframe.

For safety reasons the practice did not as a rule accept repeat prescriptions over the phone.

Concerns and complaints

The practice had a system in place for handling complaints. 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 in the practice. We saw that the practice took complaints seriously and was agreeable to learning from complaints. The practice responded to complainants in an open and timely manner. Complaints were discussed at clinical governance meetings and the practice maintained a complaints log to help identify any areas for improvement. For example, most complaints in 2013 had been about the appointment system and in response to this, the practice had introduced a telephone GP triage and consultation system to increase the number of patients GPs could treat each day.

Are services well-led?

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

Our findings

Leadership and culture

There was a strong commitment within the practice to clinical governance and the creation of an environment in which excellence in clinical care could flourish. This included, for example, protected time for the clinical governance lead GP to carry out their role and an established clinical audit programme for the practice.

The practice took part in monthly cluster meetings to develop primary medical services in collaboration with other practices in its locality. For example, it offered these practices access to its headache clinic which was run by a GP with a special interest in this area. It was working to extend and formalise such arrangements by entering into a collaborative alliance with other practices. The practice had identified the areas of expertise and skill that it would bring to the collaborative alliance, for example clinical audit and patient participation and complaints management.

One of the GPs at the practice was a member of the Newham Clinical Commissioning Group (CCG) Board. The CCG was responsible for planning and commissioning health services for Newham residents.

Governance arrangements

There were well defined arrangements and lines of accountability for decision-making for clinical effectiveness and safety and for managing risk and performance. These revolved around the monthly clinical governance meetings where safeguarding, significant events, key performance indicators, clinical audits, complaints and new guidelines were discussed. The meetings were attended by all GPs and managers and representatives from the reception, health care assistant and nursing teams to cascade information to and from their team. There was a GP lead for clinical governance. The clinical governance lead job description set out what the role entailed and that an average of four hours per week should be given over to the role. The minutes of the monthly clinical governance meetings held in March to June 2014 showed they were well attended and dealt effectively with clinical governance matters.

Systems to monitor and improve quality and improvement (leadership)

Minutes of the monthly clinical governance meetings showed systems were in place to monitor and improve services including significant events, clinical audits, complaints, safeguarding and feedback from staff. Information from all these sources was discussed at these meetings and ways of doing things better in future were agreed.

The practice took part in Newham Clinical Commissioning Group (CCG) led audits and locality meetings to benchmark its performance against other practices, share learning, and develop better systems with other services across the locality. The practice had taken part in prescribing audits to ensure GPs were prescribing effectively, and had attended meetings to review referrals to hospitals to ensure patients were getting the right care at the right time and in the right setting. We were unable to assess the impact of this work as part of our inspection.

Patient experience and involvement

The practice had involved the Patient Reference Group (PRG) in the design the practice's annual survey in 2013-14 to ensure it focussed on patients' concerns and suggestions. There were questions for example on the automated telephone system for booking an appointment, repeat prescriptions, and queuing at reception. The practice had developed an action plan with the PRG to address areas for improvements highlighted by the survey, and had published the survey results and action plan in full on its website in February 2014. It was difficult to see what progress had been made on the action plan, however. At the time of our inspection there was no update on the website. The minutes of the PRG meeting in April 2014 were on the website but did not refer directly to the action plan.

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

The practice's governance arrangements provided staff with a means of giving feedback on the running of the practice. Staff at all levels of the practice we spoke with told us the arrangements in place were effective for sharing information, escalating concerns, and resolving problems. For example, a receptionist told us suggestions they had made about the implementation of telephone triage and consultation service had been adopted by the practice which made them feel engaged in the process.

Are services well-led?

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

The practice responded to reviews left by patients on the NHS choices website, taking this opportunity to explain how the practice was trying to improve or to encourage patients to make a formal complaint so that their concerns could be investigated fully. We saw that the practice took complaints seriously and was agreeable to learning from complaints. The practice responded to complainants in an open and timely manner.

Management lead through learning and improvement

Staff objectives focussed on improving the performance of the practice and there were opportunities for staff to develop their skills and interests. For example, staff had been developed into senior reception and healthcare assistant roles. Staff we spoke with were highly motivated and committed to providing the best patient care possible.

Identification and management of risk

The practice maintained a risk register and there was a lead GP for risk management. Risks to the sustainability and effective operation of the practice had been identified and assessed. The risk register described actions to mitigate these risks, however the actions were not specific, measurable or time-bound. Nor was it clear who was responsible for carrying out the actions. This made it difficult for the practice to be assured that action had been taken and was effective.

Older people

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

Our findings

Some of the older patients we spoke with were particularly unhappy with the telephone triage and consultation system. They missed the reassurance of being seen by a GP and felt that they had to keep trying to make different people understand their needs. They told us that a few reception staff were offhand and dismissive of them.

All the patients we spoke with valued the treatment and care they received from the GPs, nurses and health care assistants, and from most of the reception staff most of the time.

We observed staff to be caring and considerate towards older patients.

The practice had informed all patients aged over 75 who their named, accountable GP was. There was a plan in place to ensure patients aged 70 year (and 79 years as a catch-up) received the shingles vaccine as part of the NHS vaccination programme. The practice was monitoring its performance against national and local targets relating to older people's care, for example completing dementia assessments, to ensure it met the targets by 31 March 2015.

Older patients with long term conditions received regular health checks and reviews, and health promotion advice to keep them as well as possible. There were clinical audit cycles to ensure these patients received effective care in line with best practice guidelines, for example checking how patients taking anticoagulants were monitored to prevent side-effects.

The practice worked with the locality extended primary care team and virtual ward to ensure patients received appropriate coordinated multidisciplinary care, for example to support a patient's discharge from hospital and rehabilitation at home.

People with long term conditions

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

Our findings

There were systems in place for GPs, practice nurses and health care assistants to complete regular checks and reviews of patients with cardiovascular disease, asthma and chronic obstructive pulmonary disease (COPD), and diabetes. Health promotion leaflets were readily available and appointments had been extended to give more time over to health advice and information. For example an appointment for diabetes education lasted 30 minutes.

Reception staff had access to electronic diary information for patients with chronic conditions to ensure they booked their reviews when they contacted the practice on other matters. Staff preparing repeat prescriptions took this opportunity also to check the diary information and to communicate to patients any outstanding reviews, blood tests, health screening, or vaccinations.

The practice checked its performance against national and local targets, for example for providing diabetes education and for influenza immunisations for at-risk patients, to ensure it met the targets by 31 March 2015.

The treatment and care of patients with long term conditions was reviewed with specialists. For example the practice met regularly with the diabetes specialist nurse and palliative care nurse. The practice also completed clinical audit cycles to ensure patients received effective care in line with best practice, for example checking that guidelines for monitoring patients on disease-modifying anti-rheumatic drugs (DMARDs) were being adhered to because of the potentially serious side-effects of these drugs.

All the patients we spoke with valued the treatment and care they received from the GPs, nurses and health care assistants, and most of the reception staff most of the time. We observed staff to be caring and considerate towards patients with long term conditions.

Mothers, babies, children and young people

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

Our findings

GPs and staff were up–to-date with safeguarding children training, were aware of the signs of abuse and took action to protect children from abuse.

The midwife attended the practice each Monday morning and patients we spoke were very happy with the liaison between the midwifery service and the practice. A system was in place to ensure pregnant women were given the pertussis, or whooping cough, vaccination as recommended by the Department of Health.

The practice was meeting its target for childhood immunisations and preschool boosters. It had also identified the number of children and young people potentially unprotected from measles, mumps and rubella (MMR) as part of the national vaccination catch-up campaign in England.

A system was in place to ensure babies and children were always prioritised for an urgent GP call back.

The practice provided free confidential chlamydia tests for young people. It was encouraging them to have the test by sending texts to young people on its list aged 18 and over.

Working age people (and those recently retired)

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

Our findings

The practice opened extended hours to meet the needs of working age people and others. It opened at 8am Monday to Saturday and stayed open to 7pm Monday to Wednesday and on Fridays. The practice had online facilities for ordering or viewing repeat prescriptions and booking a GP telephone call back for the convenience of patients.

A system was in place to ensure patients took up the health promotion and prevention services available to them, including vascular risk assessment, atrial fibrillation (AF) screening and influenza immunisations for patients aged over 65 years, and cervical screening and breast screening reminders for women. Patients aged between 16 and 50 years from high risk countries in the last 10 years were offered TB screening and TB counselling if the results was positive.

The practice provided sexual health clinics where the full range of contraceptive choices was offered, including insertion of the intrauterine device (IUD) or coil and emergency contraception.

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

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

Our findings

GPs and staff were up–to-date with safeguarding adults training and were aware of the signs of abuse and the action to take to protect vulnerable adults from abuse.

GPs and staff we spoke with demonstrated sensitivity and understanding in meeting the needs of people fleeing domestic violence, for example, taking care to emphasise confidentiality.

One of the GPs was trained in the management of drug misuse and there was an addictions worker available at the practice. There was a weekly substance misuse clinic at the practice to support access to treatment for people who used drugs problematically.

The practice was screening newly registered patients aged over 16 years for alcohol consumption as part of the national Alcohol Related Risk Reduction Scheme. The aim of the scheme was to identify and offer treatment to patients who drink alcohol at a harmful level and dependent drinkers.

The practice provided an in-house phlebotomy service for those patients who found it difficult to attend the standard phlebotomy service.

The practice had a plan in place to ensure all patients with learning disabilities had an annual health review in 2014-2015. Patients with learning disabilities were prioritised for GP call backs and were given longer appointment slots. We spoke with a few parents of people with learning disabilities and they were very pleased with the healthy lifestyle advice and support that had been given to their children.

People experiencing poor mental health

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

Our findings

The practice had a lead GP for mental health to improve services for patients experiencing poor mental health. There was a range of services at the practice to meet the needs of patients experiencing poor mental health. The practice also referred patients to the Improved Access to Psychological Therapy service (IAPT) in Newham and to specialist psychiatric services where indicated.

The practice employed a cognitive behavioural therapy (CBT) nurse consultant. This health professional provided expert advice and training to GPs at the practice and also ran a support group at the practice for patients who are compulsive hoarders. We received feedback from patients that the CBT service was very flexible, providing appointments early and late in the day to fit around patients' work commitments.

GPs held monthly meetings with a psychiatrist to review treatment plans for patients with complex mental health needs. There was regular liaison with the community psychiatric nurse (CPN) and multidisciplinary team to ensure patients received coordinated care from professionals.

Patients who took their medication in the form of a depot injection could have the injection at the practice if they chose, for convenience.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because fire action notices had not been completed to include fire assembly point details, fire marshal details, and the contact details for emergency services, fire doors were propped open and there were no notices to remind people not to use the lift in the event of a fire. Regulation 15 (1) (c) (ii).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services were not protected against the risk associated with the unsafe use and management of medicines because an anaphylaxis kit we looked at was two months past its expiry date and not fit for use, and the temperature of one of the fridges in which medicines requiring cold storage were kept was not routinely checked and monitored to ensure these medicines were stored at the correct temperature at all times and fit for use. Regulation 13.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person did not ensure that service users; persons employed for the purpose of the carrying on of the regulated activity; and others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are

This section is primarily information for the provider

Compliance actions

protected against identifiable risks of acquiring such an infection by the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection because there were no formal infection control audits as part of the system for checking that all policies and procedures for preventing healthcare acquired infection were being adhered to within the practice. Regulation 12 (1) (a) (b) (c) (2) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not ensure that information specified in Schedule 3 was available in respect of persons employed since February 2013 for the purposes of carrying on the regulated activity to demonstrate people were appointed who were of good character, had the necessary qualifications, skills and experience and were physically and mentally fit for their role. Regulation 21 (b).