Boleyn Road Practice

Inspection report

162 Boleyn Road
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London
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No website

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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.

Overall summary

We previously carried out an announced comprehensive inspection of Boleyn Road Practice on 13 July 2018 and found that the practice was in breach of Regulation 17: 'Good governance' of the Health and Social Care Act 2008. In line with the Care Quality Commission's (CQC) enforcement processes, we issued a warning notice which required Boleyn Road Practice to comply with the Regulations by 31 October 2018.

The full report of the 13 July 2018 inspection can be found by selecting the 'all reports' link for Boleyn Road Practice on our website at www.cqc.org.uk.

We carried out this announced focused inspection on 13 December 2018 to check whether the practice had addressed the issues in the warning notice and now met the legal requirements. This report covers our findings in relation to those requirements and will not change the current ratings held by the practice.

At the inspection on 13 December 2018 we found the provider had taken action to address the requirements of the Regulation 17 warning notice, except in relation to the system for monitoring staff training.

Our key findings were as follows:

- The system for monitoring staff training was not effective.
- The practice had taken action to ensure premises and equipment were fit for use.
- There was medical equipment in place for use in an emergency which was regularly checked.
- The system for receiving and acting upon safety alerts was effective.
- The practice had business improvement and business continuity plans in place.
- There was no evidence of underutilisation of appointments.
- Practice staff were able to interrogate the clinical system and extract accurate data.
- The practice was aware of low GP patient survey scores and had analysed results of the Friends and Family test, but there was no documented action plan to monitor, discuss and address all patient feedback on an ongoing basis.

We identified a Regulation that was not being met and the provider **must**:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

You can see full details of the Regulation not being met at the end of this report.

We also identified areas where the provider **should** make improvements:

- Consider documenting serial numbers in the reception log book for prescriptions taken by clinicians to consultation rooms.
- Review how the practice analyses, discusses, actions and monitors patient feedback on an ongoing basis.
- Consider documenting the regular checks of clinicians' registration.
- Ensure the recruitment policy identifies what checks the practice carries out to ensure new staff are appropriately qualified and safe.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Please refer to the detailed report and evidence table for further information.

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) inspector. The team included a GP specialist adviser and a CQC inspection manager.

Background to Boleyn Road Practice

Boleyn Road Practice is situated within NHS Newham Clinical Commissioning Group (CCG) at 162 Boleyn Road, Forest Gate, London E7 9QJ. The practice provides services to approximately 6,356 patients under a General Medical Services (GMS) contract.

The practice is registered with the CQC to carry on the regulated activities of: diagnostic and screening procedures; maternity and midwifery services; family planning; and treatment of disease, disorder or injury.

Clinical staff at the practice consist of a female partner GP, four long-term locum GPs (three male and one female), a female practice nurse and a female healthcare assistant. Non-clinical staff include a practice manager, a reception manager, and a team of reception and administrative staff.

Information received from the practice prior to the previous inspection indicates it is open Monday to Friday from 9am to 1pm and from 3pm to 6.30pm, except Thursdays when the practice closes at 1pm. During weekdays, the reception area closes with shutters down and doors closed from 1pm to 3pm. Telephone lines close from 12pm to 3.30pm.

Consultation times are Monday to Friday from 9.30am to 12pm and from 3.30pm to 6.30pm, except Thursdays which has a morning surgery only until 12pm. The practice is closed Saturdays, Sundays and Bank Holidays. The local out of hours (OOH) provider covers weekday daytime hours when the practice is closed from 6.30pm to 8pm, and Saturdays and Sundays when telephone lines are diverted to the OOH provider.

Patients can use a seven day per week GP access service commissioned by Newham CCG running from three local practice hubs Monday to Friday from 6.30pm to 10pm, and Saturdays and Sundays from 8am to 8pm. Appointments include home visits, telephone consultations and online pre-bookable appointments. Urgent appointments are available for patients who need them.

Information published by Public Health England rates the level of deprivation within the practice population group as three on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

Are services safe?

At our previous inspection on 13 July 2018, we rated the practice as inadequate for providing safe services because: safeguarding arrangements were not effective; recruitment processes and staff checks did not ensure safety; there were no systems in place to ensure premises and equipment remained fit for use; there was a lack of security and monitoring of prescriptions; and systems for safety alerts were not effective.

The practice had made improvements to comply with the Regulations when we undertook the focused inspection on 13 December 2018.

Safety systems and processes

- The practice had effective safeguarding arrangements. There was a safeguarding policy in place which identified the lead GP as the practice safeguarding lead and included contact details for the Local Authority. Staff we spoke to told us that the safeguarding lead was the lead GP. We saw evidence of up to date adult and child safeguarding training for the healthcare assistant, and up to date adult safeguarding training for the practice manager; however, the practice manager's child safeguarding training was only valid until 27 June 2017.
- One member of non-clinical staff was working without a DBS check; however, all non-clinical and clinical staff had signed written declarations confirming they had no criminal convictions, had not been the subject of any criminal proceedings, and would inform the practice manager if any criminal proceedings were commenced against them.
- The recruitment policy we were provided with did not specify what checks the practice would carry out to ensure new staff were appropriately qualified and safe. The practice manager told us that regular checks of the registration of clinical staff are completed, usually on a quarterly basis. However, these checks were not documented.
- There was professional indemnity insurance in place for clinical staff.
- The practice had a copy of the healthcare assistant's immunisation status.
- Portable appliance testing and fixed wire safety testing had been completed.
- A health and safety risk assessment had been completed and recommendations had been actioned.
- The practice had a fire policy in place which was up to date and detailed the responsibilities of staff members in relation to fire safety.

Appropriate and safe use of medicines

- Prescriptions were kept securely and their use was monitored through a written log kept in reception. Clinicians who needed prescriptions would sign the log to identify how many prescriptions had been taken and which consultation room they were taken to, although the specific serial numbers of the prescriptions taken to rooms was not recorded.
- The practice had medical oxygen and a defibrillator for use in an emergency; both were in date and in good working order and we saw evidence of regular checks.

Lessons learned and improvements made

- The system for recording and acting upon safety alerts was effective. We saw a written log in which all alerts and the action taken by the practice was recorded.

Please refer to the evidence table for further information.

Are services well-led?

At our previous inspection on 13 July 2018, we rated the practice as inadequate for providing a well-led service because: leadership capability did not underpin delivery of effective systems; the practice had not carried out analysis of the registered patients to meet the needs of the local population; there was no strategy or business plan to establish priorities and deliver improvement; the business continuity plan was out of date; staff learning and development processes were not effective; the practice did not ensure that accurate, complete and contemporaneous records were being maintained securely; there were no systems or processes to evaluate and improve practice in respect of the processing of the information obtained throughout the governance process; and there were no systems or processes to seek and act upon patient feedback.

The practice had made improvements to comply with the Regulations when we undertook the focused inspection on 13 December 2018, although the system for monitoring staff training was not effective.

Leadership, vision, strategy and culture

- The provider demonstrated an awareness of the needs of the local population and was able to explain how the practice tailors the service to meet those needs.
- The practice had a business plan in place which identified areas of improvement for the practice including changes to premises, low patient survey scores, and appointment access. The plan identified how improvements would be measured and the frequency of monitoring.
- We saw evidence that the nurse had time booked out specifically to complete training.
- We checked the gaps in training which had been identified at the previous inspection. We saw certificates of fire safety training for staff, except for one of the sessional GPs which was not provided. We saw evidence of up to date adult and child safeguarding training for the healthcare assistant, and up to date adult safeguarding training for the practice manager; however, the practice manager's child safeguarding training was only valid until 27 June 2017. The practice manager had a training matrix which set out the dates of training completed by clinical and non-clinical staff members, but this required updating and had not identified gaps in staff training.

Governance arrangements and managing risk and performance

- We saw an organisational chart for the practice which set out the job titles of all staff members, however it did not identify who were leads in certain areas of individuals' specific responsibilities.
- The practice had identified named leads or staff members responsible for infection control, safeguarding and information governance, which were documented in practice policies.
- The practice had a business continuity plan in place, hard copies of which were kept at the practice and off-site. The plan contained up to date staffing information and contact details.
- In relation to covering staff absence, the practice had recently employed an additional full-time receptionist. Non-clinical staff were responsible for arranging their own cover when they booked annual leave, or the practice manager would arrange this if there was sickness absence. The practice manager told us that other administrative or reception staff, the practice manager or some of the clinicians could provide cover and assistance if required.
- When we checked the appointment system there was no evidence of underutilisation of appointments. Practice staff explained that, previously, when the healthcare assistant was completing paperwork or other non-clinical duties this was not booked out on the appointment system, so these sessions displayed as available appointments which had not been used. We checked the appointment system and saw that sessions used for paperwork or non-clinical duties for the healthcare assistant were now blocked out.

Appropriate and accurate information

- Practice staff were able to interrogate the clinical system and extract accurate data.
- The practice had removed the ability for patients to self-identify as carers through the automatic appointment check-in screen and we saw evidence that the practice had made significant progress in updating the carers register on the clinical system; at the previous inspection 16% of patients were identified as carers, this had been reduced to 2%. Forms had been produced for patients to complete if they were carers, providing details of those they cared for.

Are services well-led?

- When we checked records on the clinical system we saw that information regarding chaperones was being recorded accurately.
- The practice had an information governance policy in place, which identified the practice manager as the information governance lead. We saw that clinical staff had completed information governance and data handling training.

Engagement with patients, the public, staff and external partners

- The most recent GP patient survey results for the practice were significantly below the national average and the practice manager was aware of these low scores and the number of surveys returned by patients. The practice manager told us that the results of the Friends and Family test were collated and we saw evidence of the results and any patient comments recorded from August 2017 to August 2018; however, there was no formal analysis of the results to identify themes or areas of improvement, or any documented action plan to monitor and address all patient feedback on an ongoing basis.

Please refer to the evidence table for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operated ineffectively, in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular: The system for monitoring of staff training was ineffective, as the training matrix required updating and gaps in staff training had not been identified.