All Saints Practice

Quality Report

21 Newby Place
Poplar
London
E14 0EY
Tel: 020 7093 3895
Website:http://allsaintspractice.org.uk/

Date of inspection visit: 1 September 2017
Date of publication: 09/11/2017

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?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
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 All Saints Practice on 28 November 2016. The overall rating for the practice was Inadequate and the practice was placed in special measures for a period of six months.

Some of the issues found were;

- There was no formal system in place for managing patient safety alerts.
- There were no arrangements in place to assure the safe management of medicines such as vaccines are followed in accordance with practice's cold chain policy.
- The practice did not ensure that significant events were investigated thoroughly and recorded in accordance with the practice's significant event policy.
- Risks to patients were not always assessed and well managed; the practice did not risk assess the absence of certain emergency medicines for e.g. GTN spray/ tablets.

The full comprehensive report on the 28 November 2016 inspection can be found by selecting the 'all reports' link for All Saints Practice on our website at www.cqc.org.uk.

This inspection was undertaken following the period of special measures and was an announced comprehensive inspection on 1 September 2017. Overall the practice is now rated as Requires Improvement.

Our key findings were as follows:

- Staff understood their responsibility to formally report incidents, near misses and concerns; we saw evidence that significant events were recorded and investigated in a timely way, discussed at clinical and practice meetings and learning was shared.

Summary of findings

- The practice had a number of policies and procedures to govern activity, for example there was a cold chain policy, which had set escalations as a significant event including to the provider for the Hurley Clinical Partnership and NHS England.
- Risks to patients were assessed and well managed.
- There was a system in place for highlighting, monitoring and cascading patient safety alerts; however staff were not always aware of current evidence based guidance, such as NICE.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Patients informed us that they were treated with compassion, dignity and respect. However they stated that the lack of enough GPs made it difficult to feel involved in decisions about their care and treatment, as well as finding it difficult to make appointments.
- Information about services and how to complain was available and easy to understand.
- The practice offered early morning and late evening appointment to meet the needs of the local population. Patients were also able to make appointments online.
- 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.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care, in particular in relation to NICE guidelines
- Continue to develop an ongoing programme that demonstrates continuous quality improvements to patient care in a range of clinical areas. This may include clinical audit.
- Although the results are improving the practice should continue to assess, monitor and improve the access to and satisfaction with appointments in view of the low patient survey results.

I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by the service.

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?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were learned and shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, 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.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- Cold chain breaches were reported as significant events and reported to the Hurley Clinical Partnership and NHS England, all fridges had data recorders on them which meant that any spikes in temperature were captured even when the practice was closed.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- Clinical staff told us they assessed needs and delivered care in line with relevant evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. However on the day of inspection the practice could not demonstrate that they were following the latest guidelines or their own policies.
- Clinical meetings were held, and we saw evidence of updates and protocols being discussed, however clinical actions were not noted.
- Data from the 2015/16 Quality and Outcomes Framework showed patient outcomes were average compared to the CCG and national averages. For example; the percentage of patients with asthma, on the register, who have had an asthma

Summary of findings

review in the preceding 12 months that includes an assessment of asthma control was 78% compared to the Clinical Commissioning Group(CCG) average of 74% and the national average of 76%.

- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 86% compared to the CCG average of 88% and the national average of 83%.
- Staff sought patients' consent to care and treatment in line with relevant legislation and guidance.
- The practice engaged with local multi-disciplinary teams (MDTs) in the community. The actions from these were not noted on patient's notes.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

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 practice lower than others for several aspects of care. For example, 78% of patients said the GP was good at listening to them (CCG average 84% national average 87%) and 77% of patients said they had confidence and trust in the last GP they saw (CCG average 88%; national average 92%).
- Survey information we reviewed showed that 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 accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 1.5% of its patients as carers, and had a member of staff who acted as a carers' champion.
- The practice had good facilities in place to accommodate patients with limited mobility and there was an elevator/lift that patients used to access treatment rooms located on the first floor.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

Summary of findings

- The national GP patient survey showed that 61% of patients said they could get an appointment to see or speak to someone the last time they tried (CCG average 79% national average 84%).
- 74% say the last GP they saw or spoke to was good at involving them in decisions about their care (CCG average 80% national average 82%).
- 43% of patients said that the last appointment they got was convenient (CCG average 74% national average 81%).
- The practice offered early morning and late evening appointment to meet the needs of the local population. Patients were also able to make appointments online.
- Patients we spoke to on the day told us they were able to book an appointment with a named GP but felt more GPs were needed. The practice was actively trying to recruit permanent GPs.
- Urgent appointments were available on the day following GPs triage.
- The practice offered various clinics to meet the needs of their patients, for example a chronic disease clinic every Wednesday.
- The practice and the Patient Participation Group (PPG) had produced a practice newsletter to signpost patients to services and other practice news.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Lessons were learned from individual concerns, complaints and also from analysis of trends and action were taken to as a result to improve the quality of care across the Hurley Clinical Partnership practices

Are services well-led?

Requires improvement

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

- Survey results for both the quality of care and access to appointments had both shown improvement hut were still lower than local and national results.
- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers.. However any actions from these meetings were not added to patients notes.
- Staff were clear about the vision and their responsibilities.
- The practice utilised the Red, Amber and Green (RAG) system. RAG is an internal tool used within the network of practices to improve the quality of care provided for patients.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- Regular staff meetings were held and minutes of these meetings were kept.
- Staff had regular days out and felt their culture was respected and taken into consideration by management for example; the practice observed and celebrated religious days such as Eid.

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 is rated as requires improvement for effective, responsive and well-led, and good for safe and caring. The evidence which led to these ratings affected all patients including this population group.

- The practice offered home visits with the duty doctor.
- The practice took part in the complex care plan admissions avoidance, which is an incentive scheme to identify the top 5% of patients who were most at risk of avoidable unplanned admissions. These patients all had alerts on their medical records which highlighted their vulnerability to the reception staff.
- There were accessible facilities available and the practice had an elevator to access treatment rooms on first floor.
- Every patient over 75 had an allocated GP and extended appointments were allocated when required.
- The practice carried out an end of life planning audit to improve patient care.

People with long term conditions

Requires improvement

The provider is rated as requires improvement for effective, responsive and well-led, and good for safe and caring. The evidence which led to these ratings affected all patients including this population group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice nurse offered a chronic disease clinic every Wednesday.
- Nationally reported data showed that outcomes for patients with long term conditions were in line or above CCG and national averages. For example, the percentage of patients with diabetes in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 76% compared to the CCG of 82% and national average of 78%.This was achieved with an exception rate of 4% which was the same as the CCG average and lower than the national average of 9%.
- Electronic care plans for patients were populated with a clinical oversight and MDT meetings arranged opportunistically.

Summary of findings

- Longer appointments and home visits were available when patients needed them.
- The practice worked closely with the district nursing team who served as both a formal and informal early warning system.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care, however, actions from these meetings were not always noted on the patients notes.

Families, children and young people

Requires improvement

The provider is rated as requires improvement for effective, responsive and well-led, and good for safe and caring. The evidence which led to these ratings affected all patients including this population group.

- The practice's had a risk register for both adults and children deemed vulnerable, this was regularly updated
- Immunisation rates for the standard childhood immunisations were in line with local CCG and national averages. For example, childhood immunisations rates for under two year olds ranged from 82% to 92% and five year olds from 85% to 91% for the practice. This was in line with the CCG averages of 88% to 91% and national averages of 88% to 94%.
- Appointments were available outside of school hours and any child under five presenting as an urgent patient would be seen on the same day.
- There was a baby changing area as well as a room available if a mother wanted to breastfeed in private.
- The practice held a weekly baby clinic.

Working age people (including those recently retired and students)

Requires improvement

The provider is rated as requires improvement for effective, responsive and well-led, and good for safe and caring. The evidence which led to these ratings affected all patients including this population group.

- The practice was open 6 days per week. Monday to Friday 8am to 8pm and Saturday 9am to 5pm.
- There was online access to book appointments, online consultations and patients could request repeat prescriptions through the practice website.

Summary of findings

- The practice uptake for the cervical screening programme was 72%, in line with both the CCG and national averages of 78% and 81% respectively. However this was achieved with an exception rate of 15%, compared to the CCG average of 9% and national average of 7%.
- The practice encouraged new patients to register which could be done online or visiting the practice in person.
- Patients aged 40–74 had access to appropriate health assessments and checks that were followed up where abnormalities or risk factors were identified.

People whose circumstances may make them vulnerable

Requires improvement

The provider is rated as requires improvement for effective, responsive and well-led, and good for safe and caring. The evidence which led to these ratings affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- The practice offered longer appointments for patients with a learning disability.
- Annual reviews were arranged and carried out centrally within the network of practices.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider is rated as requires improvement for effective, responsive and well-led, and good for safe and caring. The evidence which led to these ratings affected all patients including this population group.

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 Months was 91% which was

comparable to the CCG average of 90% and national average of 89%. This had been achieved with an exception rate of 0% compared to the local CCG average of 5% and national average of 10%.

- The practice regularly worked with multi-disciplinary teams in caring for people experiencing poor mental health, including those with dementia.
- The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Patients had access following referral to a dedicated psychologist based within the practice.
- 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.
- The lead GP at the practice undertook two clinical sessions per week at a local care home for patients with a diagnosis of dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with local and national averages. 366 survey forms were distributed and 86 were returned. This represented a 24% response rate.

- 66% (previously 62%) of patients described the overall experience of this GP practice as good compared with the CCG average of 78% (previously 77%) and the national average of 85% (no change).
- 37% (previously 38%) of patients described their experience of making an appointment as good compared with the CCG average of 67% (previously 65%) and the national average of 73% (no change).
- 59% (previously 50%) of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 72% (previously 73%) national average of 77% (previously 79%).

We spoke with 12 patients during the inspection. The patients said they were satisfied with the care they received and thought staff were approachable, committed and caring, some patients mentioned delays in getting appointments and thought the practice needed more GP's.

The friends and family test results showed that 57% of patients could usually see the GP or nurse they wanted to see and 70% (78% nationally) said would recommend the practice to someone new to the area.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care, in particular in relation to NICE guidelines.
- Although the results are improving the practice should continue to assess, monitor and improve the access to and satisfaction with appointments in view of the low patient survey results.
- Continue to develop an ongoing programme that demonstrates continuous quality improvements to patient care in a range of clinical areas. This may include clinical audit.

All Saints Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a Nurse specialist adviser and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service

Background to All Saints Practice

All Saints Practice provides primary medical services to approximately 6700 patients through an alternative personal medical services contract (APMS) for Tower Hamlets CCG. (APMS is one of the three contracting routes that have been available to enable commissioning of primary medical services) It is located in a purpose built building at 21 Newby Place, Poplar London, E14 0EY. All Saints practice operates regulated activities from one location and is registered with the Care Quality Commission to provide;

- Treatment of disease, disorder and injury.
- Family planning.
- Maternity and midwifery.
- Diagnostic and screening procedures.
- Surgical procedures.

The practice is run by Hurley Clinical Partnership who provides centralised clinical governance, managerial, finance and training across all sites Hurley Partnership Practices including All Saints Practice. Services are provided to patients from a purpose built facility in Poplar, Tower Hamlets on a busy high road and is managed and maintained by Community Health Partnerships (CHP). The purpose built facility accommodates another Gough Walk Practice and various other healthcare services operate from this site. The reception area is shared between the two practices. The practice is accessible via public transportation and parking facilities are available at the rear of the practice.

Based on data available from Public Health England (PHE), the practice is located in one of the most deprived areas. The level of deprivation within the practice population group is rated as one on a scale of one to 10. Level one represents the highest levels of deprivation. Compared to the national average the practice has a higher proportion of patients between 20 and 40 and lower proportions of patients over 40 years of age. Data obtained from the (2011) census showed that there are a high percentage of patients from Bangladeshi background and other minority groups living in Tower Hamlets.

The medical team is made up of a lead GP (male) working six clinical and two management sessions a week. The salaried GP (female) works two sessions a week but was on maternity leave at the time of the inspection. There are three locum GPs (two male, one female) from the Hurley Medical Bank who cover 25 sessions per week and a full-time nurse independent prescriber (female), full-time practice nurse (female) and a part time health care assistant (female). The clinical team are supported by a practice manager, receptionists and various administrative staff.

The practice is open Mondays to Saturdays; the phone lines are open from 8:00am to 6:30pm. Monday to Friday the practice is open between 8am and 8pm and on a Saturday 9am to 5pm. GP appointments are available from 8am to 8pm Monday to Friday and from 9am to 5pm on Saturdays.

Detailed findings

Same day appointments are triaged by a GP, and an appointment is booked if deemed urgent. The out of hours service is provided by Tower Hamlets Out of Hours GP service and can be accessed by ringing the practice's telephone after 6:30pm where the call is then diverted or the patient can telephone directly using the local rate telephone number which is on the practice website and in the practice leaflet.

Why we carried out this inspection

We undertook a comprehensive inspection of All Saints Practice on 28 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe, caring and well led services and was placed into special measures for a period of six months.

We undertook a further announced comprehensive inspection of All Saints Practice on 1 September 2017. This inspection was carried out following the period of special measures to ensure improvements had been made and to assess whether the practice could come out of special measures.

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 1 September 2017. During our visit we:

- Spoke with a range of staff (GPs, Practice manager, Practice Nurse and Administration staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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.

Good

Are services safe?

Our findings

At our previous inspection on 28 November 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect safety alerts, emergency medicines and cold chain management were poor.

These arrangements had significantly improved when we undertook a follow up inspection on 1 September 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form 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).
- From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, when a new patient was admitted to the local nursing home after a stay in the hospital, the patient's written records were not updated with an allergy to Trimethoprim and the practice did not receive an electronic copy of the notes on their computer system. The patient later had a prescription from the practice and had an allergic reaction and had to be treated in hospital. This was discussed at a significant event meeting, the patient records were updated and the practice updated its procedures so that any new patient whose records are not received electronically would have a summary requested from their former GP.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding 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 member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. The nurses had been trained to level two and administration staff trained to level one.
- 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 appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice

minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal). Cold chain breaches were reported as significant events and were escalated to the Hurley Clinical Partnership and NHSE, all fridges had data recorders on them which meant that any spikes in temperature were captured even when the practice was closed.

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines and vaccines in line with legislation.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements 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 training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. 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.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 28 November 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of care being delivered in line with relevant evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and clinical audits needed improving.

There had been some improvements when we undertook a follow up inspection on 1 September 2017; however some issues required further attention. The provider is rated as requires improvement for providing effective services.

Effective needs assessment

Clinical staff told us they assessed needs and delivered care in line with relevant evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. There was evidence of clearly defined systems and policies in place to ensure all clinical staff kept up to date with latest guidance and best practice; however, clinical staff were not able to access or demonstrate that new guidelines were monitored, when asked to show the latest guidelines on diabetes we were shown NICE guidelines from 2013, although there had been more recent guidelines since then. Clinical meetings were held and the NICE guidelines were a standing agenda item and we saw minutes where they were discussed.

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 compared with the clinical commissioning group (CCG) and national averages of 95%, with 8% exception reporting which was comparable to the CCG average of 6% and national average of 10%. 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.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was comparable to local and national averages. For example, the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 76% which was comparable to the CCG average 85% and the same as the national average. Exception reporting was 4% compared the CCG average of 6% and 13% nationally.
- The percentage of patients with hypertension having regular blood pressure tests was 86%, which was comparable to the CCG average of 88% and the national average of 83%. Exception reporting was 3% which was the same as the CCG average and comparable to the national average of 4%.
- Performance for mental health related indicators was lower than the national average. For example, the percentage of patients diagnosed with a mental health condition who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 77% compared with the CCG and the national average of 89%. Exception reporting for dementia was 4% compared to 7% within the CCG and 13% nationally.

There was evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last two years, both of these were completed audits where the improvements made were implemented and monitored.

Findings were used by the practice to improve services. For example, the practice carried out an end of life care audit in order to improve care for patients. They looked at patients in the practice who had died in the last year and had been included on their palliative care register, and how many of the patients had non-cancer conditions. The first cycle found that the percentage of deaths in the practice (0.79%) was lower than the national average despite the fact that the practice provided care to a nursing home. They found

that the number of patients who died and were on the palliative care register was higher compared to the national figures, and 90% of patients died in their preferred place of death. The practice realised that the place of death had not always coded on their computer system and that needed to be done. Prior to the second cycle the practice had improved the coding of last days of life patients as well as the preferred place of death. They had also implemented a Bereavement policy, which included sending out a bereavement card to the family of the deceased.

- The second cycle showed a reduced overall percentage of deaths.
- The percentage of patient deaths on their palliative care register who had cancer had increased by 1% from the previous year.
- They found they needed to improve the care planning for the non-nursing home palliative patients.
- 100% of deaths occurred in the patient's preferred place of death.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge 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. For example the nurse had additional training in diabetes, cardiovascular disease (CVD), asthma and chronic obstructive pulmonary disease (COPD).
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All 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.
- From the examples we reviewed we found that 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. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

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.

Requires improvement

Are services effective?

(for example, treatment is effective)

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.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. 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.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice uptake for the cervical screening programme was 72%, in line with both the CCG and national averages of 78% and 81% respectively. However this was achieved with an exception rate of 15%, compared to the CCG average of 9% and national average of 7%.

We reviewed childhood immunisation rates for the period 1 April 2015 to 31 March 2016 and found that the practice had achieved the target rate of 90% in one of four childhood immunisations and between 82%-84% in the remaining three. The practice childhood immunisation rates given to five year olds which ranged from 85% to 91% (CCG average ranged from 88% to 91% and national average from 88% to 94%).

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems 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. For example, 51% of women aged between 50 and 70 were screened for breast cancer in the preceding 36 months compared to a CCG average of 56% and a national average of 73% and 35% of patients aged 60 to 69 were screened for bowel cancer in the last 30 months, compared to the CCG average of 42% and the national average of 58%.

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

At our previous inspection on 28 November 2017, we rated the practice as inadequate for providing caring services as the practice had below average ratings for several aspects of care and there was no carer's information in the practice.

These arrangements had significantly improved when we undertook a follow up inspection on 1 September 2017. The provider is now rated as good for providing caring services. Kindness, dignity, respect and compassion.

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We spoke with 12 patients including two members of the patient participation group (PPG). The patients said they were satisfied with the care they received and thought staff were approachable, committed and caring, some patients mentioned delays in getting appointments and thought the practice needed more GP's.

Results from the 2017 national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and nurses but there had been some improvements. For example:

- 76% (previously 78%) of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% (previously 84%) and the national average of 89%(no change).
- 73% (previously 67%) of patients said the GP gave them enough time compared to the CCG average of 80% (no change) and the national average of 86% (previously 87%).
- 91% (previously 88%) of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% (previously 92%) and the national average of 95% (no change).
- 73% (previously 66%) of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 86% (previously 85%).
- 84% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 83% and the national average of 91%.
- 82% of patients said the nurse gave them enough time compared with the CCG average of 83% and the national average of 92%.
- 95% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 93% and the national average of 97%.
- 82% (previously 57%) of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 81% (no change) national average of 91%(no change).
- 82% (Previously 76%) of patients said they found the receptionists at the practice helpful which was comparable to the CCG average of 87% (previously 84%) and comparable to the national average of 87% (no change).

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.

Results from the national GP patient survey showed patients responses were below CCG and national average to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 75% (previously 69%) of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 80% (previously 81%) and the national average of 86% (no change).

Good

Are services caring?

- 74% (previously 62%) of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 76% (previously 77%) and the national average of 82%(no change).
- 81% (previously 61%) of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 77% (previously 76%) and the national average of 85% (no change).

  The practice were aware of these results and whilst they had improved they had carried out their own surveys, the most recent being July 2017 the results were;
- 77% of patients asked would recommend the practice to friends and family.
- 88% of patients asked were satisfied with their consultation.
- 96% of patients asked found the reception team helpful.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- The practice had an advocate who spoke Bengali who attended the practice every Wednesday to assist patients during their appointments.
- The practice had carried out an end of life audit to improve patient care.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.
- Annual review for patients with learning disabilities.

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. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 104 patients as carers (1.5% of the practice list). Written information was available to direct carers to the various avenues of support available to them. The practice held meetings for carers and a member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 28 November 2016, we rated the practice as requires improvement for providing responsive services as the arrangements in respect of continuity of care and access to appointments.

While these arrangements had shown some signs of improvement when we undertook a follow up inspection on 1 September 2017, some areas still required improvement. The practice is still rated as requires improvement for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered early morning and late evening appointments Monday to Friday 8am to 8pm for patients who could not attend during normal opening hours. They were also open from 9am to 5pm on Saturdays.
- 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.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS or were referred to other clinics for vaccines only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services.
- There were two lifts to access first floor consulting rooms.
- The practice worked closely with a local care home looking after people with dementia that had over 70 residents. Two clinical sessions were delivered at the home weekly.
- The practice offered various clinics to meet the needs of their patients, for example a chronic disease clinic every Wednesday.
- Other reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services.

Access to the service

The practice was open Mondays to Saturdays. Monday to Friday the practice opened between 8am and 8pm and on a Saturday 9am to 5pm. GP appointments were available from 8am to 8pm Monday to Friday and from 9am to 5pm on Saturdays. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

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

- 78% (previously 79%) of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) at 76% (previously 77%) and the national averages of 76% (previously 79%).
- 59% (previously 43%) of patients said they could get through easily to the practice by phone compared to the CCG average of 68% (previously 67%) and the national average of 71% (previously 73%).
- 61% (previously 55%)of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 79% (previously 70%) and the national average of 84% (previously 76%).
- 43% of patients said their last appointment was convenient compared with the CCG average of 74% and the national average of 81%.
- 37% (previously 38%) of patients described their experience of making an appointment as good compared with the CCG average of 67% (previously 65%) and the national average of 73% (no change).
- 42% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 47% and the national average of 58%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The practice had acted on low patients score by increasing access to appointments utilising eConsult, the GP triaging on the day so that the nurse could see more appropriate patients and by increasing the number of clinical sessions which helped to reduce the waiting time for routine appointments. The survey scores however had not yet fully reflected the changes made but had improved. The practice kept monitoring this by carrying out their own monthly audits, the most recent being July 2017 the results were;

- 58% of patients asked could get an appointment easily.
- 66% of patients asked could usually see the GP or nurse they wanted to see.
- 88% of patients asked were seen within 30 minutes of arriving at the practice.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The reception team recorded the patient details specifically requesting the home visit and these were passed onto the duty doctor who carried out a telephone consultation and arranged a home visit if clinically necessary. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice operations manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, including a leaflet and a poster.

We looked at four complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, when a parent was waiting for the test results for their child, the practice realised that the sample had not been sent to the lab. The practice apologised to the parent. This was discussed at an administration meeting and procedures were amended to act on late test results sooner.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 28 November 2016, we rated the practice as inadequate for providing well-led services as management could not adequately demonstrate that policies and procedures were always followed in relation to the management of significant events, medicines and safety alerts, cold chain and emergency medicines. There was an overarching governance framework but this needed significant strengthening to ensure effective oversight.

We issued requirement notices in respect of these issues and found arrangements had improved when we undertook a follow up inspection of the service on 1 September 2017. The practice is now rated as requires improvement for being well-led.

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas, for example the practice nurse led in the management of all patients with long term conditions.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- Survey results for both the quality of care and access to appointments had both shown improvement hut were still lower than local and national results.
- The practice did carry out some clinical and internal audit which was used to monitor quality and to make improvements. For example the recent end of life audit resulted in improved care for the local care home residents.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of meetings of a structure that allowed for lessons to be learned and shared following significant events and complaints.
- The practice had guidelines with regard to acting on or referring to NICE guidelines we saw evidence that this was discussed at meetings when asked to show the latest guidelines on diabetes we were shown NICE guidelines from 2013.

Leadership and culture

On the day of inspection the practice demonstrated they had the experience and capability to run the practice and ensure high quality care and had put together an action plan to address the issues found at the previous inspection. They were aware that employing more permanent GPs would improve continuity of care and access to appointments. They 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 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).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a

Are services well-led?

Requires improvement

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

culture of openness and honesty. From the sample of two documented examples we reviewed we found that the practice had systems 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 and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns. However any actions from these meetings were not added to patients notes.
- Staff told us the practice held regular team meetings.
- 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. Minutes were comprehensive and were available for practice staff to view.
- 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 and staff. It proactively sought feedback from:

- Patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG produced a practice newsletter to inform patients of important updates and news and to also encourage more patient participation.
- The practice had acted on poor patient feedback by increasing access to appointments utilising eConsult, the GP triaging on the day so that the nurse could see more appropriate patients and by increasing the number of clinical sessions available and reducing the waiting time for routine appointments. The survey scores however had not yet fully reflected the changes made but had improved. The practice kept monitoring this by carrying out their own monthly audits.NHS Friends and Family test, complaints and compliments received.Staff through meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice.

The practice offered a service called eConsult which was an online self-triage and patient information service that aimed to provide better access for patients at a time convenient to them.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The systems and processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided were ineffective. In particular, the practice were not following their own guidelines with regard to acting on or referring to NICE guidelines: Patient notes should include all interactions with other healthcare professionals. Low uptake of health screening, such as bowel cancer and cervical screening. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.