City Wellbeing Practice

Quality Report

129 Cannon Street Road
London
E1 2LX
Tel: 020 7488 4240
Website: citywellbeingpractice.nhs.uk

Date of inspection visit: 19 November 2014
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

City Wellbeing Practice is a GP practice which provides primary medical care to nearly 7000 patients in the Whitechapel area of east London. The practice operates a branch surgery on two afternoons per week at Portsoken Health Centre, 14-16 Little Somerset Street, London E1 8AH but this was not inspected as part of this visit. Services provided include minor surgery (injections only), phlebotomy and a range of nurse led clinics such as antenatal, diabetes and sexual health. It is situated in an ethnically diverse inner city area with high levels of deprivation.

We carried out an announced comprehensive inspection on 19 November 2014.

The practice is rated as good overall.

Our key findings were as follows:

- patients were treated with kindness and respect and involved in making decisions about their care
- patients were generally satisfied with the ease of getting through on the phone and the availability of appointments at the practice.
- safe systems were generally in place to monitor and manage individual patient care and safety
- care was planned and delivered effectively and patients underwent regular monitoring and medicines reviews
- patients reported that they felt listened to
- staff worked well with multidisciplinary teams to coordinate care for patients
- the practice was responsive to patient's needs and acted on feedback from them to improve the service
- the practice was clean and infection control measures in place

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

Importantly, the provider must:

Summary of findings

- Ensure that staff receive training in the safeguarding of vulnerable adults and implement a procedure for safeguarding vulnerable adults. Review the system for reviewing vulnerable children on the practice database.

In addition the provider should:

- formalise the system for ensuring all staff are aware and taking any necessary action on medical updates and safety alerts
- implement a procedure for the security of blank prescription forms in accordance with national guidance
- introduce a system for carrying out full-cycle clinical audits
- review and update the health and safety risk assessment
- carry out a Legionella risk assessment
- ensure staff undergo fire safety training and carry out regular fire safety drills
- place information on opening and appointment times in the reception/waiting area

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. The practice had a system in place for reporting, recording and taking appropriate action following significant events and incidents. Although risks to patients who used services were assessed, some of the systems and processes to address these risks were not implemented well enough to keep patients safe. For example there were no processes for staff with safeguarding concerns regarding vulnerable adults and the process for reviewing vulnerable children was not robust. A fire risk assessment had been carried in February 2014 which identified areas of concern but staff were not trained in fire safety and had not carried out fire drills.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs identified and planned in staff appraisals. Staff worked in multidisciplinary teams to coordinate patient care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed complaints were addressed appropriately and staff learned from complaints.

Are services well-led?

Good

The practice is rated as well-led. Staff were aware of the vision and strategy and their responsibilities in relation to it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and there were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions and appraisals and attended regular staff meetings.

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

Good

The practice is rated as good for the care of older people. Care and treatment of older people did not always reflect current evidence – based practice, and some older people did not have updated care plans. Older people had same day access to a doctor and telephone consultations were available. Longer appointments and home visits were available and older patients all had a named GP. The practice provided care planning and worked with district nurses and other healthcare professionals to provide an integrated care plan for those 98 patients in the top 2% at high risk of unplanned admissions to hospital. However, nationally reported data showed that outcomes for patients for conditions commonly found in older people, such as dementia, were below average with 82% dementia reviews carried out.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. These patients had structured annual reviews to check that their health and medication needs were being met. Multidisciplinary team meetings with other community healthcare professionals were held throughout the year and doctors discussed care plans to facilitate coordinated care for patients with long term conditions to prevent admissions to hospital.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were high for all standard childhood immunisations. Staff told us children and young people were treated in an age-appropriate way and recognised as individuals and we saw evidence to confirm this. Appointments were available outside school hours and the premises were suitable for children and babies. There was good joint working with the midwife who ran a weekly clinic there. There were systems in place to identify vulnerable children who were at risk but they were not always followed up.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people, including those recently retired and students. The practice provided extended opening hours and was open every Saturday morning to accommodate the needs of those working during weekdays. Online

Summary of findings

appointment booking and repeat prescriptions services were advertised and available. Data available on a range of health promotion and screening activities such as carrying out blood pressure and health checks on new patients and over 40 year olds, indicated that the practice was performing above the CCG average in these areas. Staff from the practice, including a GP, promoted and held health awareness sessions in the community.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice registered different vulnerable groups such as homeless people and they were able to use the practice address to receive healthcare communication. The practice held a register and had a system for carrying out annual health reviews for those with a learning disability.

Staff had not received training in the safeguarding of vulnerable adults and there was no process, including contact details, of how to refer a vulnerable adult to relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 75% of patients experiencing poor mental health and 82% of patients with dementia had received an annual review which was below the CCG average. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health and dementia. The practice told patients experiencing poor mental health about how to access various support agencies such as MIND and local counselling services.

Summary of findings

What people who use the service say

We spoke to 15 patients including two members of the patient participation group (PPG). They all told us they were very happy with the care and treatment provided by all the staff at the practice and said they were treated with dignity, respect and compassion They told us they received good care and treatment and both clinical and reception staff took time to explain things to them. 5 patients completed comment cards which were left in the reception area and four were very positive about the service they received at the practice.

Before our visit we reviewed the results of an independent national GP survey of the practice carried out in 2014 which found that the practice was rated as average for patients describing their overall experience as "good" or "very good". Most patients found it easy to get through on the phone and the practice GPs were better than average at involving them in decisions about their care. The practice was below average for satisfaction scores on consultations with the nurse.

Areas for improvement

Action the service MUST take to improve

- Ensure that staff receive training in the safeguarding of vulnerable adults and implement a procedure for safeguarding vulnerable adults. Review the system for reviewing vulnerable children on the practice database.

Action the service SHOULD take to improve

- formalise the system for ensuring all staff are aware and taking any necessary action on medical updates and safety alerts
- implement a procedure for the security of blank prescription forms in accordance with national guidance
- introduce a system for carrying out full-cycle clinical audits
- review and update the health and safety risk assessment
- carry out a legionella risk assessment
- ensure staff undergo fire safety training and carry out regular fire safety drills
- place information on opening and appointment times in the reception/waiting area

City Wellbeing Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Inspector. The team included a GP and Expert by Experience; all team members had the same powers held by the CQC Lead Inspector to inspect the regulated provider.

Background to City Wellbeing Practice

City Wellbeing Practice is a GP practice which provides primary medical care to nearly 7000 patients in the Whitechapel area of east London. The practice operates a branch surgery on two afternoons per week at Portsoken Health Centre, 14-16 Little Somerset Street, London E1 8AH but this was not inspected as part of this visit. Services provided include minor surgery (injections only), phlebotomy and a range of nurse led clinics such as antenatal, diabetes and sexual health. It is situated in an ethnically diverse inner city area with high levels of deprivation. There were a higher than average number of patients aged between 20 and 49 years with a lower number of older patients above 55 years old. 50% of the practice population are of Bangladeshi origin and there are high numbers of patients who do not speak English as a first language.

There are three GP partners (two female and one male) and a female salaried GP. There is one long term locum GP who is covering for one of the partners who is currently on maternity leave, a part time female practice nurse and full time health care assistant practitioner, practice manager and four reception/administration staff. The practice is a teaching practice for medical students.

GPs have opted out of providing out-of-hours services to their own patients and employ the services of an out of hours provider to fulfil this role. Information within the practice and in the practice leaflet and website advertises telephone contact details for patients to call if they have medical problems after the surgery is closed or at weekends. The practice holds a general medical services contract (GMS) with NHS England [A GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities].

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice. We talked to Tower Hamlets Clinical Commissioning Group (CCG). We carried out an announced visit on 19 November 2014. During our visit we spoke with a range of staff (one GP partner, one salaried GP, healthcare assistant practitioner, practice manager, and three administration/reception staff. We spoke with 15 patients including two who were members of the Patient Participation Group (PPG). We reviewed treatment records of patients and looked at the practice's policies, procedures and audits. We reviewed management and staff files and five comment cards which patients had posted on the reception desk.

Detailed findings

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Staff were aware of their responsibilities and understood their role and the processes for reporting incidents and complaints that affected patient's safety. They told us that when an incident occurred they often discussed it straightaway with a GP or manager before completing the report form known as a Significant Event Analysis (SEA). These SEAs were then discussed every month at the practice meetings. We reviewed the minutes of five of these meetings over the last year and found that significant events were an item on the agenda at each one. This showed that the practice had managed these consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw examples of significant events which had been recorded on a form and included details on discussion and learning points for staff, as well as review dates. We noted that different staff had completed these forms. One event involved a patient who fainted in the nurse's room. The nurse was able to call other staff to help her with the patient but was unaware of the alert procedure on the computer which would have alerted other staff immediately to attend the room. This event led to the practice nurse being shown the alert system and other staff having a training drill on the procedure.

National patient safety alerts were received by one member of staff and disseminated to the rest of the practice team electronically. Staff we spoke to were able to give examples of recent alerts, such as the Ebola outbreak in West Africa, but there was no formal system of discussing these alerts and actioning them.

Reliable safety systems and processes including safeguarding

The practice had a policy and an appointed dedicated GP lead for safeguarding children but not for the safeguarding of vulnerable adults. All staff we spoke with were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern. We looked at training records which showed that all staff had received role specific and up to date training in the safeguarding of children, such as level 3 for doctors and level 2 for nurses. Staff had not undertaken safeguarding training for vulnerable adults but the practice manager told us this had been booked for staff to attend in February 2015.

Staff told us how they would recognise signs of abuse in children and knew how to escalate and refer those concerns. The referral process and contact details were available in the reception area should a member of staff have any safeguarding children concerns. However, there was no process and contact details of relevant agencies for the referral of vulnerable adults.

The practice did not have sufficiently robust systems to manage and review risks to vulnerable children. Although the clinical records of these children were appropriately coded there were no alerts placed on electronic patient records which would have enabled clinicians and other staff to know immediately that there were safeguarding concerns with the child and they needed to be reviewed. We saw one patient record where a vulnerable child had been identified but not reviewed for two years.

There was a chaperone policy and notices regarding chaperoning which were visible on the walls of the consulting and treatment rooms. They explained that patients could ask for a chaperone if they wanted one. Clinical staff told us they asked patients if they wanted a chaperone present when for example patients were undergoing an intimate examination, and noted this in patient records. Nursing and reception/administration staff had received chaperone training. They understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We saw an anonymised patient record which noted that a chaperone had been offered, but declined by the patient.

Medicines management

We checked medicines stored in the treatment rooms and medicines refrigerators and found they were stored securely and only accessible to authorised staff. Fridges used for the storage of medicines, such as vaccines, were monitored on a daily basis to ensure they were operating at the correct temperature. We saw records of temperature checks and staff knew what action to take in the event that temperatures were outside the required range.

Requires improvement

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There were protocols for the prescribing of medicines. We saw evidence of low prescribing rates and low use of non-steroidal anti-inflammatory drugs (NSAIDs) which was in line with local and national prescribing guidelines.

The nurse and health care assistant practitioner had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP (though not a locum GP) before they were given to the patient. Repeat prescriptions could be requested online and patients we spoke to said repeat prescriptions were ready within 48 hours if they came to collect them. However, we also noted that blank prescription forms were not handled in accordance with national guidance as they were not always tracked through the practice and kept securely at all times.

Cleanliness and infection control

The practice was visibly clean and tidy throughout. A cleaner, who had received infection control training, attended every working day and followed a cleaning schedule which included daily, weekly and monthly tasks. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness.

The practice nurse was the lead for infection control and all staff had undertaken up to date training in infection prevention and control. Infection prevention and control was included in staff induction training. An infection control policy and supporting procedures such as body fluid spillage and needle stick injury was available for staff to refer to so they could plan and implement measure to control infection., Personal protective equipment including disposable aprons, gloves and goggles were readily available for staff to use in treatment and consultation rooms. These rooms also had wash hand basins with supplies of soap hand gel and hand towel dispensers as well as notices about hand hygiene techniques displayed above the sinks. Sharps bins were safely located and clinical waste was appropriately stored and collected.

Internal infection control audits had been carried out and an audit by the local NHS Commissioning Unit on the 4 November 2014 had identified a number of shortfalls and given the practice an action plan with attached timescales to address those issues. The practice manager told us some immediate actions had been taken such as the removal of out of date syringes and needles and ensuring a system of checking dates on this equipment. Other issues such as carrying out a risk assessment for Legionella (a germ found in the environment which can contaminate water systems in buildings) was going to be actioned within the next two months. We saw evidence that clinical staff had hepatitis B immunity blood test checks in order to minimise the risk of spreading infections.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw the portable appliance testing (PAT) certificate which showed that electrical equipment in the practice was safe. We saw evidence that a schedule of testing and calibration of other equipment such as spirometers and blood pressure machines was carried out annually.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. Staff told us they completed an application form and attended for an interview before being employed. Criminal records checks were undertaken before staff started to work at the practice. Other recruitment checks included checks with appropriate professional bodies, identity, right to work in the UK and previous employer references. The practice employed a long term locum GP to cover maternity leave for one of the partner GPs however as this GP was known to them they had not carried out reference checks. They said they would do so immediately. For periods of unplanned leave such as sickness the practice employed the services of a locum GP agency.

Non clinical staff covered for one another during staff shortages and busy periods. There was an arrangement in place for members of staff to cover each other's annual leave. Staff had this expectation written in their contracts. Some staff were multi-skilled and one member of reception

Requires improvement

Are services safe?

staff was a summariser (staff member who summarised all medical notes and letters). Another staff member was undergoing training on the day of our visit to become a smoking cessation advisor.

The practice had induction checklists for each area of work and one new staff member told us they had completed the induction checklist before they started work and received a staff handbook which contained information on topics such as health and safety and whistleblowing. There was no induction pack available for locum GPs although the practice manager told us they were working on this.

Monitoring safety and responding to risk

The practice had a health and safety policy and information displayed for staff to see. Health and safety was also a topic covered in the staff handbook. The practice had carried out a health and safety risk assessment which detailed risks to staff and patients such as slipping and tripping on cables or objects left on the floor and actions taken to minimise those risks. This was due to be reviewed annually and was in need of updating as it had not been done for over a year.

When incidents and risks were identified, they were discussed and measures put in place to prevent a recurrence. We saw evidence that an incident with a patient who threatened staff was discussed at a practice meeting to ensure staff were aware of staff safety procedures.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff we spoke with told us they knew where the emergency equipment was located and what to do in the event of a medical emergency. The practice had an emergency medical kit, oxygen cylinder, automated external defibrillator (used to attempt to restart a person's heart in an emergency) and pulse oximeter which had been serviced and we saw records that they were regularly checked regularly. We saw evidence that staff underwent annual mandatory training in basic life support (BLS) which included training in the use of the defibrillator.

Emergency medicines were available and were stored securely. These included those for the treatment of cardiac emergencies, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Fire Safety checks of the alarm system and fire safety equipment were carried out annually within the building. A fire risk assessment had been carried out in February 2014 and this had identified a number of issues such as staff not being trained in fire safety and lack of regular fire drills. However, staff had still not been trained and had not carried out drills. We discussed this with the practice manager who told us they would arrange this as soon as possible.

The practice had a comprehensive business continuity plan to deal with a range of emergencies that may impact on the smooth running of the service. Each risk was rated and mitigating actions to be taken, including contact details of staff and outside agencies. We were told there had been a loss of electrical power last year and the emergency plan had been successfully enacted.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

When planning patient's care and treatment GPs used a variety of guidance such as National Institute for Health and Care Excellence (NICE) and local commissioners to promote best practice in areas such as end of life care and prescribing. They received update information by email and at locality and training events. They told us there was no formal system for discussing new updates and changes although they discussed them on a daily basis or at their weekly clinical meetings.

The GPs told us they lead in specialist clinical areas such as diabetes and asthma and the practice nurse, healthcare assistant practitioner and reception staff supported this work, which allowed the practice to focus on specific conditions. The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

We were shown data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. National data showed that the practice was in line with referral rates to secondary and other community care services for most conditions. There was below average referral for cardiology and colorectal surgery and above average referral in ear, nose and throat (ENT), dermatology and orthopaedics. The practice told us they had reviewed their ENT referral rates in the light of this and attended specific GP ENT training and updated guidelines. It was too early to measure the impact of these changes and they had not completed an audit.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and medicines management. The practice had carried out some prescribing audits and used the results to improve outcomes for patients. We saw evidence to show that the practice was performing well within the CCG area with respect to rate of antibiotic prescribing and percentage of ibuprofen and naproxen with respect to all non-steroidal anti-inflammatory drugs (NSAIDs).

One GP told us that clinical audits were often linked to medicines management information, safety alerts or data from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, QOF figures showed the practice had carried out 75% of reviews on cancer patients which was below the CCG average. Clinical staff were carrying out an audit on cancer reviews at the present time with the aim of improving this figure but it was too early to analyse results. However, there was no system in place to carry out other clinical and practice management audits and complete full audit cycles to enable staff to regularly assess and monitor the quality of the services provided.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 94% patients of patients with a mental health disability had a care plan in their medical records which was above the CCG average. The practice met all the minimum standards for QOF in chronic obstructive pulmonary disease (COPD), asthma and hypertension.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long term conditions such as diabetes. For example, 83% diabetic patients had a foot check and 97% had an eye check. Each diabetic patient was given a copy of their care plan. We reviewed some diabetic care plans and found they were comprehensive, detailed and enabled the patient to easily assess how they were managing their condition.

The practice had a palliative care register and had monthly clinical as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was also a register of patients with learning disabilities and a system of annual review. Patents with dementia had a care plan and 82% of them had had an annual review which was below the CCG average.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Practice staffing included medical, nursing managerial and reception/administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performer's list with NHS England).

All staff undertook annual appraisals that identified learning needs and areas for development. The nursing staff had their appraisal with a GP. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant course, for example the healthcare assistant practitioner told us they had started working at the practice as a receptionist and had been supported and trained to become a healthcare assistant and then practitioner.

The practice nurse and healthcare assistant practitioner were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties, for example, on administration of vaccines and spirometry. Those with extended roles, seeing patients with long term conditions such as diabetes, were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice manager told us how they had managed and dealt with an incidence of poor performance and appropriate action had been taken to manage this.

Working with colleagues and other services

The practice had established relationships and worked with other services to meet patients' needs and manage complex cases. It received blood test results, X ray results, letters from the local hospital and reports from the out of hours services both electronically and by post. Staff were clear on their responsibilities in relation to passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. They rerouted information regarding patient results to the GP on call if the patient's named GP was on leave.

The practice held multidisciplinary team meetings every month to discuss the needs of complex patients. They used a risk tool which was a management programme for patients with long term conditions such as heart failure. These meetings were attended by district nurses, palliative care nurse, social workers and a case manager to discuss and coordinate care for these patients. Staff felt the meetings worked well. One aim was to coordinate care for 98 patients in the top 2% of being at risk of being admitted to hospital (unplanned admissions). Patients had been reviewed and had care plans in place. We reviewed five care plans and found information in them was missing although we found evidence of notes on discussions and care in the patient records. We discussed this with clinicians and they told us there had been some problems with the template they used for the care plans but these were being resolved.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the out of hours service to enable patient reports to be shared in a secure and timely manner. Electronic systems were in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). One patient we spoke to confirmed the doctor had helped them to use this system to make an appointment at the local hospital.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, to coordinate, document and mange patients' care. This software enabled scanned paper communications, such as those from hospital to be saved in the system for future reference. We asked but were told that record audits were not carried out.

Consent to care and treatment

The practice had a consent policy which set out the types of consent and how to obtain and record it. We saw an anonymised record where consent was documented.

Staff were familiar with the principles of the Mental Capacity Act 2005 and the Childrens Act 1989 and 2004 and demonstrated they understood issues around informed consent. They were able to explain how they would assess patients for capacity and obtain consent.

Good

Are services effective?

(for example, treatment is effective)

Staff understood the Gillick competencies and told us they would assess a patient such as a teenager requesting contraception and document it in their records.

Health promotion and prevention

All new patients were offered a health check with the healthcare assistant practitioner and this included checking their weight and blood pressure whilst also giving them an opportunity to discuss lifestyle factors affecting their health and wellbeing such as smoking or drinking alcohol. 96% patients over the age of 40 had blood pressure checks and this was above the CCG average.

Information on a range of topics and health promotion leaflets were available in the waiting area. One member of staff was trained and another undergoing training as smoking cessation advisors. Once smokers had been identified in the patient population they were offered an initial meeting then further meetings as required. 91% of patients recorded as smokers had been offered help and advice to stop smoking.

Staff from the practice, including a GP, promoted and held health awareness sessions in the community. Topics covered cancer, long term condition management and medication awareness and events were held in venues such as mosques and schools to reach a wide range of the population.

Systems were in place to ensure that children received their childhood vaccinations and in the last year 96% of under 2 year olds had been immunised for measles, mumps and rubella (MMR). The figure was slightly lower (94%)for children under 5 years but these figures were higher than the local target which had been set. The cervical smear uptake rate was 81% which was above the CCG average. Patients over the age of 65 and other vulnerable groups were offered flu, shingles and pneumococcal vaccinations. 79% of these patients had received a flu vaccination which was above the national rate of immunisation.

The practice ran in-house midwife clinics as well as dedicated mother and baby clinics. They used these clinics to provide health and wellbeing advice opportunistically to patients. Chlamydia screening was offered to patients over the age of 15.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a patient survey undertaken with input from the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the 2014 National Patient survey found that the practice was "average" for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors with 82% of practice respondents saying the GP was good at treating them with care and concern and 84% said the GP was good at listening to them. The practice was below average for satisfaction scores on consultations with the nurse with 66% saying the last nurse they saw or spoke to was good at giving them enough time.

Patients completed comment cards to tell us what they thought about the practice. We received five completed cards and four were very positive about the service received. One negative comment related to the length of time it took to get an appointment. We also spoke to 15 patients including two members of the patient participation group (PPG). They all told us they were satisfied with the care and treatment provided by all the staff at the practice and said they were treated with dignity, respect and compassion. Patients said they felt the practice offered a really good service and staff were polite and professional. They commented that the healthcare assistant practitioner was very good and doctors were very considerate.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that conversations taking place in these rooms could not be overheard.

Staff had received training in information security and governance and were aware of the practice's confidentiality policy. A confidentiality statement on the practice website explained how patient information was treated. During the course of our inspection we observed staff speaking to patients kindly and found that patients in the waiting area could not easily hear what was happening at the reception. Reception staff told us that if patients wanted to speak with them confidentially they were able to take them to a quiet area and one patient confirmed they had done this.

Staff told us that they would treat patients whose circumstances may make them vulnerable, with sensitivity. They had no one at present registered at the practice who was homeless or on a temporary visa but they did have in the past and told us they let these patients use the practice address to receive healthcare information. Staff had undergone training in sexual orientation, equality and diversity and told us of examples of how they dealt with patients with learning disabilities and poor mental health.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed that 76% of practice respondents said the GP involved them in care decisions and 81% felt the GP was good at explaining treatment and results. Both these results were above average when compared to the local CCG figure.

Patients we spoke to described being listened to and supported to understand their diagnosis as well as being given options about their care and treatment. Some patients said they would like longer consultations. The doctors and health care assistant practitioner told us they always involved patients in their own treatment and care.

Translation services were available for patients who did not have English as a first language. As 50% of the patients were Bengali, a trained Bengali advocate attended the practice three times per week to provide translation services for patients. This was advertised in the reception area and some notices and leaflets were also available in other languages commonly spoken in the area. Staff told us in addition to the translator they also regularly accessed a telephone translation service.

Good

Are services caring?

Staff told us they used "You're Welcome" (a set of DH criteria for young people friendly health services). One GP visited schools to promote awareness about the practice and specific health conditions to young people.

Patient/carer support to cope emotionally with care and treatment

Staff told us that relatives and carers were given consultation time if they wanted it following a bereavement. One patient commented that they were treated with compassion by the staff following a bereavement and the doctor was particularly supportive and also referred them to a counselling service. We saw evidence that a Bereavement Befriending service had been discussed in a clinical meeting and staff were given leaflets on the service to hand to appropriate patients. There were posters in the waiting room, information screen and patients website which told patients how to access support groups and organisations

There was a separate noticeboard in the waiting area for carers with specific information on how to access support groups and there was information signposting patients to support groups for bereavement. The practice's computer system also alerted staff if people were carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. The practice had a long-standing PPG which met three to four times a year and they consulted with them before running annual patient surveys to find out the priority areas for patients. A patient survey two years ago had indicated that patients were not satisfied with the appointment system which was all pre-bookable appointments. The practice changed the system to a mix of same day, pre-bookable and telephone triage appointments. A follow-up survey carried out from July to September 2014 showed that there were some positive responses by patients to the changes and 78% were happy with the telephone triage service. Patients we spoke to said they had no problems with the appointment system although they felt they would like longer appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice was situated on the ground floor and the entrance and waiting area were spacious enough to accommodate people with pushchairs and wheelchairs. There was also a ramp to the entrance and a disabled access toilet.

Practice staff used the services of a Bengali advocate to translate and they attended regularly each week. They also used telephone translation services when appropriate. Between them the staff spoke a range of languages commonly spoken in the community. The service acted to remove barriers with patients who may find it difficult to access the service. Homeless patients who attended the practice were able to register with them and use the surgery as their address. Home visits were arranged for housebound patients so that care plans could be put in place and these patients were included in integrated care planning. Older patients were screened for dementia opportunistically when they attended the practice. Teenagers were not turned away if they attended the practice.

A midwife attended every week to provide antenatal care for pregnant women and there was a well baby clinic for child health surveillance.

Staff training records indicated they had undertaken e-learning training courses in equalities, diversity and human rights within the last 12 months.

Access to the service

Appointments were available from 9am to 12pm and 2.30pm to 6pm each weekday. There was also a Saturday morning surgery available from 9am until 12pm. The practice's extended opening hours on a Saturday morning was useful to patients with work commitments. Appointments were available outside of school hours for families, children and young people. All morning appointments were released from 8.30 onwards when patients could contact the practice by telephone. If patients needed an urgent appointment they could have one on the same day and when they were fully booked, a telephone triage appointment with a duty GP was offered. For routine appointments patients may have to wait up to two weeks if they wanted to see a doctor of their choice.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments online. However there was no information outside the practice entrance or inside the reception regarding opening and appointment times. Patients were also sent a text message reminder for appointments and test results. Older patients and those with long term conditions were offered home visits where necessary. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out of hours service was provided to patients in the practice leaflet and website.

Longer appointments were also available for patients who needed them and those with long term conditions. Older patients had a named GP.

Patents were generally satisfied with the appointments system. Comments received from patients showed that patients in urgent need of treatment could see or speak to a doctor on the same day as contacting the practice. One patient said the doctors were excellent about contacting them on the same day.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system because a "Complaints, suggestions, comments?" leaflet was available in the reception area which set out how to make a complaint. There was information on the website about who to complain to. The practice also monitored patient comments on the NHS Choices website and when appropriate invited those making adverse comments to make a complaint so that the issue could be investigated. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We reviewed the records of the last two years of complaints and found that there was a documented audit trail for all complaints that were made. This showed the concern raised, the investigation undertaken and the outcomes for the complainant and the practice.

The practice annually reviewed complaints to detect themes or trends. We looked at the report for the last review in April 2014 of five complaints made in the last year, and no themes had been identified. However, lessons learned from individual complaints had been acted on. One complaint concerned a patient who had received a text message regarding a campaign to prevent practice closures and felt this was a misuse of the facility. The practice reviewed it's procedure for text messaging and now only texts regarding patient appointments and health campaigns related to a patient's condition were sent.

The practice manager said they or a doctor would try to speak to the patient making the complaint initially if that was appropriate to see if they could resolve the matter promptly. Staff were clear about how complaints were managed and said that any complaints were discussed immediately if necessary and also discussed in practice meetings each month to ensure they could learn and improve. We reviewed the minutes of six recent staff meetings and found that complaints were on the agenda of each meeting, if there were any.

Are services well-led?

Good

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

Our findings

Vision and strategy

GP partners expressed their vision and strategy as improving the health and wellbeing of patients by working in partnership with them. They were aware to potential risks to the quality of care they provided because of an increasingly diverse practice population in a highly deprived area and aimed to have a family friendly and welcoming practice.

We spoke to five members of staff and they were able to describe similar values and felt there was a good relationship and communication between staff and between staff and patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared computer drive within the practice. There was a clear leadership structure with named members of staff in lead roles. For example, there was a GP childrens' safeguarding lead and the practice nurse was the infection control lead.

We spoke with five members of staff and they were all clear about their own roles and responsibilities. They demonstrated they had the knowledge and experience to fulfil these roles in order to provide care, support and treatment for patients. They told us they felt well supported and knew who to go to in the practice with any concerns.

The practice used the QOF to measure it's performance. The QOF data for this practice showed it was performing in line with national standards. They did not carry out formal peer reviews although clinicians told us they measured their performance in areas such as prescribing and referral rates at network locality meetings with neighbouring practices.

The practice had carried out audits, such as prescribing audits, which were contractual obligations. Other audits had been carried out, such as that of patients at high risk of unplanned admissions, but there was not a systematic programme of clinical and practice audits including a full-cycle of auditing. We saw evidence that improvements to performance had been made as a result of some audits.

Leadership, openness and transparency

Whole practice team meetings were held every month and these were followed by clinician meetings. Staff told us that there was an open culture and that the doctors and practice manager were very approachable. They said they were able to voice their concerns and before meetings were asked if there was anything they would like to have on the agenda.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of procedures, for example a risk assessment for a pregnant member of staff. Staff received a staff handbook which included information such as the procedure for whistleblowing should staff have concerns about other staff and how the practice was run.

Practice seeks and acts on feedback from its patients, the public and staff

Formal staff surveys were not carried out but the practice gathered staff feedback through meetings, appraisals and day to day discussions. Staff felt their views were listened to and acted on if necessary. Staff told us they were able to give feedback and discuss concerns or issues with colleagues and management. One member of nursing staff told us that they had asked for specific training around ear irrigation and were supported to do it. Staff told us they felt involved and engaged in the practice to improve outcomes for patients.

The practice had a long-standing patient participation group (PPG) and the practice worked at trying to ensure the group reflected the patient population by putting up information in the waiting room and on the website about how the activities of the group and how to join. The PPG carried out annual surveys and met every quarter. The results of the last surveys and analysis reports about the last three years were available on the practice website.

The practice gathered feedback from patients through regular surveys carried out by the PPG, surveys carried out by an independent research company, patient comments and complaints received and monitoring the NHS Choices website. We looked at the results of the last annual patient survey and found that 76% of patients were happy with convenience of their appointment time which was below the CCG average. As a result of this the practice had changed the appointment system and introduced a telephone triage system with a duty doctor. We reviewed a follow-up survey the practice carried out from July to

Are services well-led?

Good

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

September 2014, to determine if patients were satisfied with the new appointment system. This showed that there were some positive comments about the changes and 78% were happy with the telephone triage system particularly.

Management lead through learning and improvement

Annual individual staff appraisals took place that included personal development for the year ahead. There were management systems in place which enabled learning and supported staff to maintain their clinical professional development and improve their practice. GPs and the practice nurse received appropriate appraisals and peer support arrangements were also in place. We spoke to newly recruited staff who told us they had undertaken a formal period of induction.

We reviewed the minutes of whole practice meetings held in 2014 and found that complaints and significant events were always items on the agenda. Annual reviews of significant events and complaints were also discussed at meetings to ensure the practice improved outcomes for patients. For example, one significant event regarding the wrong information going into a patient record, meant that staff were reminded to cross check patient details before entering them on the system to try to prevent this type of error recurring. Lessons were shared informally day to day and clinicians had regular clinical meetings, which were minuted, to discuss and learn from patient cases.

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
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: Patients who use the service were not protected against the risk of abuse because there was no procedure for staff to follow if they suspected abuse in a vulnerable adult and they had not received training in the safeguarding of vulnerable adults. There was no system to review vulnerable children on the practice database Regulation 11(1)(b)