

Dr VK Chawla's Practice

Quality Report

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

Ratings

Overall rating for this service

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr VK Chawla's Practice on 5 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also rated as good for providing services for older people, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, people experiencing poor mental health (including people with dementia) and for people with long term conditions. It was rated as requires improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to infection control.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The areas where the provider must make improvements are:

- Undertake annual infection prevention and control audits in order to assess and act on possible cross infection risks.

In addition the provider should:

- Develop a systematic approach for using clinical audit cycles to drive improvement in performance and patient outcomes.

- Ensure there is a record of clinical meeting discussions so as to enable reflection on outcomes being achieved and to identify improvement areas.
- Look at ways of increasing the practice's Patient Participation Group membership so that it reflects the local population profile (a PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

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.

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?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses (including safeguarding concerns). Information about safety was recorded, monitored, appropriately reviewed and addressed. There was enough staff to keep people safe. Lessons were learned and communicated to support improvement, although sharing learning from significant events did not include non clinical staff. Emergency drugs were within expiry date and a system was in place for checking and recording dates. Staff had undertaken safeguarding training to the required level.

Risks to patients and staff were assessed and well managed with the exception of infection prevention and control. For example, the practice had not undertaken an infection prevention and control audit in over twelve months. At the time of our inspection, a legionella risk assessment had not been undertaken. We were sent confirming evidence that this had been carried out shortly after our inspection.

Requires improvement



Are services effective?

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 the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. Although some clinical audits had been started, these were incomplete and we saw no evidence they were driving improvement in performance or patient outcomes.

Good



Are services caring?

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 for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with Barking and Dagenham Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Good



Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions and regular performance reviews, and attended staff meetings and events. The practice had a number of policies and procedures to govern activity and held regular governance meetings, although these were not always minuted.

Good



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and weekly nursing home visits (including rapid access appointments for those with enhanced needs).

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and longer appointments and home visits were available when needed. Patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Good



Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Good



Summary of findings

What people who use the service say

During our inspection, we spoke with four patients including two members of the practice's Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Patients spoke positively about patient care and about how they were treated by staff.

We also reviewed 36 Care Quality Commission (CQC) patient comment cards. These had been completed by patients in the two week period before our inspection and enabled patients to share with us their experience of the practice. Feedback was positive with key themes being that staff were respectful, that they listened and were compassionate. The patient profile ranged from newly registered patients to those who had been with the practice for more than ten years.

We also used existing patient feedback to guide our discussions with patients. For example, the NHS England National GP Patient Survey 2014 (388 surveys sent out, 105 returned, 27% response rate) highlighted that 90% of respondents said that the last nurse they saw or spoke to was good at giving them enough time and that 75% of respondents said that the last GP they saw or spoke to was good at listening to them. This was consistent with patient feedback on the day of our inspection and with comment card feedback. The national survey highlighted that only 63% of respondents found reception staff helpful (compared to an 83% local practice average). However, face to face and comment card feedback were positive regarding reception staff and how they interacted with patients.

Areas for improvement

Action the service **MUST** take to improve

- Undertake annual infection prevention and control audits in order to assess and act on possible cross infection risks.

Action the service **SHOULD** take to improve

- Develop a systematic approach for using clinical audit cycles to drive improvement in performance and patient outcomes.

- Ensure there is a record of clinical meeting discussions so as to enable reflection on outcomes being achieved and to identify improvement areas.
- Look at ways of increasing the practice's Patient Participation Group membership so that it reflects the local population profile (a PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

Dr VK Chawla's 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 advisor granted the same authority to enter the registered person's premises as the CQC lead inspector.

Background to Dr VK Chawla's Practice

Dr VK Chawla's Practice is located in Barking and Dagenham, outer East London. The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities. The practice has opted out of providing out-of-hours services to their own patients.

The practice has a patient list of approximately 2,600. Approximately 10% of patients are aged 65 or older and approximately 46% are under 18 years old. Forty six percent have a long standing health condition and 18% have carer responsibilities.

The surgery is open from 9am-6.30pm Monday to Friday (including through lunch). Appointments are available from 9am-12 pm and 4pm-6.30pm. Outside these times, telephone cover is provided by an out of hours provider.

The services provided include child health care, ante and post natal care, immunisations, sexual health and contraception advice and management of long term

conditions clinics. The staff team comprises two GP partners (one female, one male), one female salaried GP, two part time female practice nurses, practice manager and a range of administrative staff.

The practice is registered with the Care Quality Commission to carry on the regulated activities of Treatment of disease, disorder or injury, Diagnostic and screening procedures and maternity and midwifery procedures.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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?

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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 5 May 2015. During our visit we spoke with a range of staff (GPs, practice nurse, practice manager and reception staff) and spoke with patients who used the service including two PPG members. We observed how people were being cared for and talked with carers and/or family members. We also reviewed comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. We reviewed safety records and incident reports where these were discussed for the last twelve months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred during the last twelve months and saw this system was followed appropriately. There was evidence that the practice had learned and shared from these events. For example, following an incident where administrative staff had taken incorrect patient details during a phone conversation, the practice had discussed the incident with administrative staff and the importance of accurate message.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw evidence of action taken as a result of significant events. For example, one significant event we reviewed related to a suspected cancer diagnosis that had not been referred within the required two week timeframe. Following the incident, the practice had provided refresher training for administrative staff and improved its systems for processing two week referrals.

National patient safety alerts were disseminated by the practice manager to practice staff. They gave examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked

at training records which showed that all GPs and practice nurses had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. All staff were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a GP as safeguarding lead for vulnerable adults and children. They had been trained in both vulnerable adults and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware of who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Practice nurses undertook chaperone duties and had received Disclosure and Barring Service (DBS) checks. 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.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators, and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures and which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Expired and unwanted medicines were disposed of in line with waste regulations.

Are services safe?

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. These had been updated in 2014. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, a reception staff member's description of how they received patient specimens was consistent with the practice's specimen handling policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The two practice nurses led on infection and prevention control at the practice. They had undertaken further training to enable them to provide advice on the practice's infection control policy and carry out staff training.

At the time of our inspection, the practice had not undertaken a risk assessment for Legionella. Shortly after our inspection we were sent confirmation that a risk assessment had taken place. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. However, notices about hand hygiene techniques were not displayed in staff and patient toilets.

The practice could not evidence that an infection prevention and control audit had taken place within the

last twelve months; in order to assess and act on possible cross infection risks. We were told that the local CCG had not yet identified an infection control lead to support the audit process.

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 equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date had been within the last twelve months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometer and blood pressure measuring devices within the last twelve months.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the

Are services safe?

building, the environment, staffing and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies).

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac

arrest, anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated) and hypoglycaemia (low blood sugar). All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk risks identified including power failure, adverse weather and unplanned sickness. The document contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The practice had carried out a fire risk assessment in 2014.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with the practice manager and a GP how NICE guidance was received into the practice. They told us this was downloaded from the website and available on PC desktops. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and were in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes had regular health checks and were referred to other services when required. Feedback from patients confirmed they were promptly referred to other services or hospital when required.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, cardio vascular disease prevention. We were able to confirm that guidelines were available on computer desktops but there was no evidence of discussion at clinical meetings.

Interviews with GPs and a practice nurse showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for

patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been started in the last year. For example, an audit of patients on the practice's hypothyroidism list took place in 2014. Hypothyroidism is a condition where the thyroid gland doesn't produce enough hormones. The audit aimed to assess whether patients were missing routine blood screening and review. This was following the removal of this group of patients from the Quality and Outcomes Framework (QOF); a system intended to improve the quality of general practice and reward good practice). This resulted in the loss of pop up alerts on the clinical computer system. The audit identified 68 patients of whom 52 (76%) had had a blood test in the last year. The audit recommended that staff be reminded to send patients on the hypothyroidism list for regular blood tests. A follow up audit round had not yet taken place.

Another audit had been triggered by CCG performance data which had highlighted relatively high non-attendance and low uptake rates for breast screening. Following an analysis, the practice had amended its systems so that it received prior notification lists and non-attendance data from Breast Screening Services (which went onto the practice's clinical computer system as alerts). All reception staff, nurses and GPs were advised of this and instructed to speak to patients about the benefits of breast screening and to encourage them to attend for their mammograms. A subsequent reaudit highlighted that the practice's actions had resulted in improved breast cancer diagnoses.

Overall, however, the practice did not have a systematic approach for using clinical audit cycles to drive improvement in performance and patient outcomes.

The practice had achieved 92.7% of the total QOF target for the latest available period in 2013/14 which was the same as the CCG average and 0.8% below the national average. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. Clinical indicators where the practice had maximised their QOF points in 2013/14 included asthma and cancer.

Are services effective?

(for example, treatment is effective)

The practice was aware of areas of QOF under performance (for example diabetic care). We were told that due to cultural reasons many patients were unfamiliar with screening. We were told that as a result, the practice had put in place more robust patient recall processes.

We also noted that the practice worked closely with the CCG Diabetic Lead. This included monthly joint clinics for patients whose diabetes was uncontrolled and who could benefit from specialist input.

The practice's prescribing rates were similar to national figures. For example the prescribing of antibiotics, hypnotic and anti-inflammatory drugs were in line with the national average. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

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. Benchmarking data showed the practice had outcomes that were slightly worse than compared to other services in the area. However, we saw evidence that the practice was taking action to improve its performance.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date regarding mandatory courses such as safeguarding, basic life support and infection control.

We noted a good skill mix among the doctors with GPs having qualifications in coils and implants; and joint injections. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP was appraised annually, and undertook a fuller assessment called revalidation every five years. Only when revalidation had been confirmed by the General Medical Council could the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, they had received training in long term conditions such as diabetes and asthma.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs such as patients experiencing poor mental health, long term conditions or with end of life care needs. These meetings were attended by district nurses, social workers and palliative care (end of life) nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. Staff felt this system worked well.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance services.

Are services effective?

(for example, treatment is effective)

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record system. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Clinical staff also demonstrated a clear understanding of the Gillick competency test. These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions. The practice had not needed to use restraint but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The patient's GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 70% of patients in this age group took up the offer of the health check. Latest available comparable performance for the cervical screening programme was 83%, which was above the national average of 77%. A practice nurse had responsibility for following up patients who did not attend and text messaging was also used. Alerts on the clinical system enabled clinicians to offer screening opportunistically. The practice encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. There were similar systems in place for non attending patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Latest available flu vaccination rates for the over 65s was 78% (which was above the national average).
- Practice data we looked at showed that childhood immunisation rates for vaccinations given at twelve months, twenty four months were generally above 90% (comparable national data was unavailable).

We noted that the reception area contained patient information on conditions which were prevalent amongst the local community such as cardiovascular disease and mental health.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction: the national patient survey 2014. This showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the National GP Patient Survey showed that 90% of patients felt that the nurses were good at giving enough time. We also noted that 92% of patients fed back that their nurse was good at listening.

Patients were positive about how they were treated by reception staff and during our inspection we observed that reception staff treated patients with dignity and respect. When we spoke with a receptionist they stressed the importance of seeing a patient as an individual. Patients spoke positively about how they were treated by GPs and nurses, and we noted that this was also consistent with CQC comment card feedback.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 36 completed cards all of which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. They were satisfied with the care provided by the practice and said their dignity and privacy were respected.

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 rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Privacy was not highlighted as a concern in any of the 36 comment cards we reviewed.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patient survey feedback was positive regarding questions about patients' involvement in planning and making decisions about care and treatment. For example:

- 87% said the last nurse they saw was good at explaining tests and treatments (compared to the CCG average of 85% and national average of 90%).
- 74% said the last GP they saw was good at involving them in decisions about their care. (compared to the CCG average of 72% and the national average of 81%).

Patients confirmed that they felt involved in decisions about their care and treatment. For example, patients with a long term condition told us they were provided with sufficient information to be able to make informed decisions about their choice of treatment. Comment card feedback was also positive and aligned with these views.

Staff told us that interpreting services were available for patients who did not have English as a first language (including British Sign Language). We saw notices in the reception areas informing patients this service was available.

The practice website and reception contained a range of information to help patients make informed decisions about their care and treatment (for example managing a long term condition).

A receptionist described the steps that she and colleagues routinely undertook to help patients who needed additional support, understand and be involved in their care.

Patient/carer support to cope emotionally with care and treatment

National patient survey feedback was also positive about the emotional support provided by the practice and rated it well in this area. For example:

- 75% said the last GP they spoke to was good at treating them with care and concern (compared to the CCG average of 76% and national average of 85%).

Are services caring?

- 89% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 90%.

Face to face and comment card feedback highlighted that staff responded compassionately when patients needed help and that they provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. We noted that 18% of patients had a caring responsibility and we were told that the practice routinely signposted patients to a local carer support network. Information was also available in the

practice reception and on the practice website. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. A carer we spoke with was positive about the care and support they received (such as the practice offering annual flu immunisation).

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

For example, we were told that between April – June 2014, the average uptake of bowel screening in Barking and Dagenham practices was 43.2% compared to the national target of 60% and the practice performance was 36.7%. The practice worked with the CCG's bowel screening team to discuss how to improve performance. This resulted in the practice contacting patients to advise them that they would be receiving a screening kit in the post (as this approach had resulted in improved screening rates in other localities) and arranging CCG led training for reception staff on how to complete the test and on the importance of screening. Reception staff, doctors and nurses were also encouraged to speak to patients about bowel screening and the practice added alerts to patient records. At the time of our inspection, data was unavailable regarding improvements in practice screening performance.

The practice could not show how it had implemented service improvements in response to PPG feedback. We were told that the practice had found it difficult to attract members and records showed that the practice was developing plans to increase membership. Three patient surveys had taken place in the last twelve months (approximately 90 patients). We were told that these were linked to the revalidation of the practice's three GPs.

However, there was evidence of how the practice had sought to improve patient satisfaction with its appointments system. In March 2015, the practice had joined a local GP federation pilot project which enabled its patients to access additional appointment slots in the evenings and on Saturdays and Sundays. The service was delivered from a local hospital approximately 30 minutes away by bus.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and the practice provided interpreters for non English speakers (including British Sign Language).

We were told that the majority of the practice population spoke English as second language and access to online and telephone interpreting services were available if they were needed. A hearing loop was installed in reception. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. The practice clinical system had alerts on the notes of patients with sensory impairments so that all staff were able to assist them within the practice.

The premises and services had been designed to meet the needs of people with disabilities. The practice was on two floors and not served by a lift. However, patients with mobility difficulties were offered appointments in ground floor treatment rooms. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with space for wheelchairs and pushchairs to easily manoeuvre. This made movement around the practice easier and helped to maintain patients' independence.

There was a system for flagging vulnerability in individual patient records. There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Staff demonstrated an understanding of equality diversity principles; such as treating patients as individuals. Records showed that they had received equality diversity and human rights training within the last twelve months.

Access to the service

The surgery is open from 9am-6.30pm Monday to Friday (including through lunch). Appointments are available from 9am-12 pm and 4pm-6.30pm. Outside these times, telephone cover is provided by an out of hours provider.

Comprehensive information was available to patients about appointments on the NHS Choices website and in the practice leaflet. This included how to arrange urgent appointments and home visits. The practice web site advised patients how they could access urgent medical

Are services responsive to people's needs?

(for example, to feedback?)

assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Home visits and longer appointments were available where needed for older people and patients with long-term conditions. Appointments were available outside of school hours for children and young people. Extended opening hours (including weekends), telephone consultations, online booking, text message appointment reminders were particularly responsive to working aged people. The practice offered flexible services and appointments; for example, avoiding booking appointments at busy times for people who may have found this stressful. Longer appointments were offered for people experiencing poor mental health.

Patient survey feedback was generally positive regarding access to appointments although lower than local and national averages. For example:

- 66% said they could get through easily to the surgery by phone compared to the CCG average of 69% and national average of 73%.
- 60% described their experience of making an appointment as good compared to the CCG average of 66% and national average of 73%.

- 74% were satisfied with the practice's opening hours which was the same as the CCG average and lower than the national average of 75%.

Patient face to face and comment card feedback was generally positive regarding the appointments system.

Listening and learning from concerns & complaints

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

We saw that information was available in the practice reception, on its website and in its patient leaflet to help patients understand the complaints system. 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.

Records showed that two complaints had been received in the last twelve months. We found that these were satisfactorily handled and dealt with in a timely way, in accordance with the practice's complaints policy.

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

The practice had a clear vision to provide the best quality service for patients within a confidential and safe environment. We did not see evidence of a business plan but discussions with staff and review of available partner and clinical meeting minutes highlighted that the practice's focus was upon good quality patient centred care and treatment.

We spoke with seven members of staff who understood the practice's vision and values and their role in relation to these vision and values.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at ten of these policies and procedures. Although there was no system in place to confirm that staff had read the policy, they demonstrated an understanding. All ten policies and procedures we looked at had been reviewed in the last twelve months.

There was a clear leadership structure with named members of staff in lead roles. For example, there were lead staff members for infection control and safeguarding. Staff were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The partner GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the QOF to measure its performance. QOF data for this practice showed it was performing in line with national standards. However, minute taking of weekly clinical meetings was infrequent and there was therefore limited evidence of how QOF data was used to maintain or improve patient outcomes.

The practice showed us two clinical audits that had been started in the last year. However, these were incomplete and the practice could not demonstrate how they had been used to drive improvements in performance and patient outcomes.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented (with the exception of infection prevention and control).

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies (such as induction and management of sickness policy) which were in place to support staff. We were also shown the electronic staff handbook that was available to all staff, which included sections on equality and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. We were told that all staff were involved in discussions about how to run the practice and how to develop the practice although we did not see minuted evidence.

Staff told us that there was an open culture within the practice and that they had the opportunity and felt confident to raise any issues at bi monthly team meetings. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice had a PPG but we were told of difficulties in attracting members. There was no evidence of a PPG action plan or of how the practice had acted on service improvement suggestions raised by the PPG. However, records showed that the practice was liaising with other local practices to explore how it could improve increase PPG membership. We saw evidence that the practice had responded to feedback left on the NHS Choices website.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They also told us that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Are services well-led?

Good 

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at clinical meetings to ensure the practice improved outcomes for patients. However, there was no evidence of how this was shared with non clinical staff.

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
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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
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	The practice was not undertaking annual infection prevention and control audits; in order to assess and act on possible cross infection risks.
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