

Dr Abul Kashem Mohammed Zakaria

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

Inadequate



Are services safe?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Inadequate



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	11
Background to Dr Abul Kashem Mohammed Zakaria	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13
Action we have told the provider to take	27

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Abul Kashem Mohammed Zakaria on 17 June 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe services and being well led. It was also inadequate for providing services for older people; people with long-term conditions; families, children and young people; working age people (including those recently retired and students); people whose circumstances make them vulnerable; and people experiencing poor mental health (including people with dementia). Improvements were also required for providing effective services. It was good for providing a caring and responsive service.

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

- The practice did not have a systematic approach to identifying risks, assessing the extent and probable impact of the risks, and putting in place effective control measures to maintain and improve patient safety.
- Some risks to patients were not well managed including risks associated with cross-infection, fire, medical emergencies, business continuity, and lack of access to a female GP.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. They commended the GP for being very hardworking, caring and approachable, and for providing a good service.
- Data showed patient outcomes were average or above average for the locality. Although some audits had been carried out, there was no on-going programme of clinical audits to monitor quality and systems to identify where action should be taken.
- Urgent appointments were available on the day they were requested and patients were usually seen within 48 hours of requesting a routine appointment unless

Summary of findings

they were booking further in advance. However patients said that they had to wait a long time to be seen after they arrived at the practice for their appointment.

- Information about services and how to complain was available and easy to understand.
- The practice had written policies and procedures to govern activity, but not all of these had been customised to reflect the practice's own arrangements. There were no written records of clinical meetings and discussions.
- Medical records did not fully document the treatment and care provided to patients.
- The practice had proactively sought feedback from patients and staff felt involved and engaged with the practice to improve outcomes for both staff and patients.
- The GP was providing joint injections for the treatment of arthritis but was not registered with CQC to carry on the regulated activity of Surgical procedures

The areas where the provider must make improvements are:

- Ensure oxygen is available and staff are up to date with basic life support training to meet the needs of patients in medical emergencies.
- Ensure risk assessments are in place so that the practice can be assured that care and treatment are being delivered in as safe a manner as possible, for example arrangements for meeting patients' GP gender preference.
- Ensure business continuity plans are in place to deal with other emergencies that may impact on the daily operation of the practice, in addition to plan the practice has in place for fire and flood.
- Ensure staff know what to do in a fire emergency.
- Ensure systems and processes are in place to prevent cross infection.

- Ensure the chaperone arrangements do not put patients at risk of abuse.
- Ensure systems are in place to assess, monitor and mitigate risks relating to the health, safety and welfare of patients.
- Ensure complete records are maintained of each patient's care and treatment and of decisions taken in relation to their care and treatment.
- Ensure other records are maintained in relation to the management of the service, for example notes of clinical meetings.
- Register with the Care Quality Commission to carry on the regulated activity Surgical procedures

In addition the provider should:

- Keep on record details of the locum GP's professional indemnity arrangements.
- Ensure systems and quality are monitored to identify where improvements can be made through completed clinical audit cycles.
- Review and customise all policies and procedures so that they reflect the practice's own arrangements.
- Continue to review its appointments system to reduce the amount of time patients wait to see the GP after they have arrived at the practice for their appointment.

On the basis of the ratings given to this practice at this inspection I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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 inadequate for providing safe services and improvements must be made. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, there was no system in place to capture this information beyond an incident book, and the incident book did not provide a framework for analysis and learning. There was also no reflection on the incident and plans to prevent future incidents. Some risks to patients were not well managed including risks associated with cross-infection, fire, medical emergencies, business continuity, staffing including chaperone arrangements, and lack of access to a female GP.

Inadequate



Are services effective?

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were largely at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) 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. Staff had received professional development appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. However, there was no evidence of completed audit cycles.

Requires improvement



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



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 the NHS England 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 with a

Good



Summary of findings

named GP and that there was continuity of care, with urgent appointments available the same day. Fewer patients waited less than 15 minutes after their appointment time compared to the Newham average. The practice was taking action to address. Patients commended the GP for his thoroughness and flexibility. 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 and other stakeholders.

Are services well-led?

The practice is rated as inadequate for being well-led. The practice had aims and objectives in place and staff were aware of their responsibilities in relation to the aims and objectives. There was a documented leadership structure and staff felt supported by management and able to approach them with issues. The practice had proactively sought feedback from patients and had an active patient participation group (PPG). However, not all policies and procedures had been customised to reflect the practice's own arrangements. There was no on-going programme of clinical audits to monitor quality and systems to identify areas for improvement. Medical records did not document fully the treatment and care provided to patients, and other records relevant to the running of the practice were not maintained for example minutes of clinical meetings. The practice did not have a systematic approach to identifying risks, assessing the extent and probable impact of the risks, and putting in place effective control measures to maintain and improve patient safety. The GP was providing joint injections for the treatment of arthritis but was not registered with CQC to carry on the regulated activity of Surgical procedures.

Inadequate



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

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 including home visits and rapid access appointments for those with enhanced needs.

The provider was rated as inadequate for providing safe services and being well led, and requires improvement for providing effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



People with long term conditions

Nursing staff had lead roles in chronic disease management. Longer appointments and home visits were available when needed. All these patients had a named GP and most had 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.

The provider was rated as inadequate for providing safe services and being well led, and requires improvement for providing effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



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 were looked after. Immunisation rates were relatively high for all standard childhood immunisations. We observed children and young people were treated in an age-appropriate way and were recognised as individuals. Staff understood the Gillick competency test. (This is 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). Appointments were available outside of school hours and the premises were suitable for children and babies.

The provider was rated as inadequate for providing safe services and being well led, and requires improvement for providing effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



Summary of findings

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 to ensure these were accessible, flexible and offered continuity of care. For example, appointments were available until 8.30pm one day a week to improve access for people at work all day. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The provider was rated as inadequate for providing safe services and being well led, and requires improvement for providing effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



People whose circumstances may make them vulnerable

The practice held a register of patients living in vulnerable circumstances including housebound people and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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.

The provider was rated as inadequate for providing safe services and being well led, and requires improvement for providing effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



People experiencing poor mental health (including people with dementia)

All of the people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Inadequate



Summary of findings

The provider was rated as inadequate for providing safe services and being well led, and requires improvement for providing effective services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

What people who use the service say

Patients completed CQC comment cards in the two weeks prior to our inspection to tell us what they thought about the practice. We received 31 completed cards most of which were very positive about the service experienced. Patients described a service that was empathetic, sympathetic, professional and approachable. They found the service easily accessible and staff to be kind and caring. Privacy and dignity were respected. They commented that the premises provided a clean and safe environment and some stated that they received excellent support for long term conditions. Many clearly valued their family GP of many years standing.

Two comments were less positive and said that waiting times to be seen could be too long, with the doctor running late. However these were accompanied by comments about the doctor's willingness to address more than one problem during a consultation and about the doctor being thorough.

We also spoke with two patients on the day of our inspection. One was very satisfied with the treatment and care received and one was not.

The results of the national GP patient survey published in January 2015 showed Dr Abul Kashem Mohammed Zakaria compared well with other practices in Newham in the following areas:

- Respondents are satisfied with the surgery's opening hours (75% compared with the Newham average of 76%).
- Respondents with a preferred GP usually got to see or speak to that GP (46% compared with the Newham average of 50%).
- Respondents had confidence and trust in the last nurse they saw or spoke to (87% compared with the Newham average of 93%).

Dr Abul Kashem Mohammed Zakaria compared less well in the following areas:

- Respondents usually wait 15 minutes or less after their appointment to be seen (31% compared with the Newham average of 51%).
- Respondents describe their experience of making an appointment as good (48% compared with the Newham average of 65%).
- Respondents would recommend this surgery to someone new to the area (50% compared with the Newham average of 67%).

This was based on a 17% survey completion rate (446 surveys sent out and 78 surveys sent back).

Areas for improvement

Action the service MUST take to improve

- Ensure oxygen is available and staff are up to date with basic life support training to meet the needs of patients in medical emergencies.
- Ensure risk assessments are in place so that the practice can be assured that care and treatment are being delivered in as safe a manner as possible, for example arrangements for meeting patients' GP gender preference.
- Ensure business continuity plans are in place to deal with other emergencies that may impact on the daily operation of the practice, in addition to plan the practice has in place for fire and flood.
- Ensure staff know what to do in a fire emergency.
- Ensure systems and processes are in place to prevent cross infection.
- Ensure the chaperone arrangements do not put patients at risk of abuse.
- Ensure systems are in place to assess, monitor and mitigate risks relating to the health, safety and welfare of patients.
- Ensure complete records are maintained of each patient's care and treatment and of decisions taken in relation to their care and treatment.
- Ensure other records are maintained in relation to the management of the service, for example notes of clinical meetings.

Summary of findings

- Register with the Care Quality Commission to carry on the regulated activity Surgical procedures.

Action the service SHOULD take to improve

- Keep on record details of the locum GP's professional indemnity arrangements.
- Ensure systems and quality are monitored to identify where improvements can be made through completed clinical audit cycles.
- Review and customise all policies and procedures so that they reflect the practice's own arrangements.
- Continue to review its appointments system to reduce the amount of time patients wait to see the GP after they have arrived at the practice for their appointment.

Dr Abul Kashem Mohammed Zakaria

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a second CQC Inspector and a GP Specialist Advisor. Specialist Advisors are granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to Dr Abul Kashem Mohammed Zakaria

Dr Abul Kashem Mohammed Zakaria, also known as Upper Road Medical Centre, is located in an urban area in the London Borough of Newham in east London. The practice has approximately 3,500 registered patients. Its opening hours are:

- Monday, Tuesday and Friday – 8.00am to 6.30pm
- Wednesday – 8.00am to 8.30pm (extended hours surgery)
- Thursday – 8.00am to 2.00pm

GP services are provided by a registered individual, Dr Abul Kashem Mohammed Zakaria, under a General Medical Services (GMS) contract with NHS England.

Services are provided by two male GPs: Dr Abul Kashem Mohammed Zakaria and another GP who works two to three sessions per week at the practice on a locum basis.

The practice also employs a part time female nurse practitioner, a part time female locum nurse, a part time female healthcare assistant, a practice manager, medical secretary, and administration and reception staff.

Dr Abul Kashem Mohammed Zakaria serves a deprived population. It is located in an area that is in the most deprived ten per cent of all areas in England. Its list of registered patients is made up of a greater proportion than the England average of people aged 20 to 39 and there are comparatively very few people aged over 65 years. The percentage of its patients with a long-standing health condition is 41.3% compared with a practice average across England of 54.0%. The percentage of its patients with caring responsibility is 19.3% compared with a practice average across England of 18.2%.

Dr Abul Kashem Mohammed Zakaria is registered with the Care Quality Commission to carry on the following regulated activities at 50 Upper Road, Plaistow, London E13 0DH: Treatment of disease, disorder or injury.

Dr Abul Kashem Mohammed Zakaria provides out-of-hours services to its own patients as part of a local co-operative of GPs providing out-of-hours cover to Newham patients.

Dr Abul Kashem Mohammed Zakaria is providing joint injections for the treatment of arthritis and should therefore be also registered to carry on the regulated activity of: Surgical procedures. The provider has been advised of this.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

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.

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?

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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew, including Healthwatch Newham, Newham Clinical Commissioning Group (CCG) and NHS England. We carried out an announced visit on 17 June 2015. During our visit we spoke with a range of staff, including the GP, the practice nurse practitioner, the Practice Manager, and administrative and reception staff. We spoke with patients who used the service and members of the Patient Participation Group. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed documentation the provider gave us about the operation, management and leadership of the service.

Are services safe?

Our findings

Safe track record

The practice used some information in an ad hoc way to improve patient safety, for example complaints. Some incidents were being recorded in the practice's incident book, primarily those relating to patients expressing dissatisfaction with reception staff because they could not see the GP when they wanted to. However we were told, or read, about other kinds of incidents that were not recorded in the incident book, for example a prescribing accident. The practice was not able to demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had an incident book. Beyond that it did not have in place a system for reporting, recording and monitoring significant events, incidents and accidents. The incident book did not record what learning, if any, was gained from any incident and how that learning was used to improve patient safety. The practice had not undertaken significant event analysis (SEA) for more than one year. We were told that it had discontinued using the SEA framework when the Clinical Commissioning Group no longer made it a requirement.

Minutes of practice meetings showed patient safety issues arising from complaints were discussed and action was agreed to bring about improvements. Staff, including receptionists, administrators and nursing staff, felt able to raise issues and concerns with the GP and practice manager.

Other documents we looked at showed the GP reflected on significant events, such as unexpected deaths, to see what, if anything, could have been done better, and to identify any further learning and development that staff could benefit from.

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 staff had received relevant role specific training on safeguarding, including the locum GP. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also 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 lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil the roles. All staff we spoke with were aware who the lead was and 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, looked after children, and housebound patients. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including community midwives.

The practice provided a chaperone where requested and notices on the waiting room noticeboard and in consulting rooms told patients about this. 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. Reception staff had been briefed on what was expected from them when they acted as a chaperone, although those we spoke with had never been called on to perform this duty. They told us patients rarely requested a chaperone. Not all non clinical staff who were expected to perform chaperone duties had received a 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.

The GP told us they would involve the female practice nurse in the consultation, or a female GP colleague from another practice on occasion, as an alternative to making a formal referral for the patient to another service when the patient expressed a preference not to be examined by a male GP. There was no risk assessment and risk management plan in place to ensure this was a safe way of meeting patients' GP gender preference. Clinical Commissioning Group was supporting the provider to recruit a female GP to work at the practice.

Are services safe?

The GP and practice nurse were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and liaised with partner agencies such as social services. The GP told us the practice followed up where children or vulnerable adults attended accident and emergency or missed appointments frequently, however this was not recorded in patients' notes that we looked at.

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, 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. Use of emergency medications was documented clearly with the drug used, batch number and date of use.

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.

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.

There was at least a part system in place for the management of high risk medicines such as methotrexate, which is used in the treatment of rheumatoid arthritis for example. Codes were used on the electronic case management system to flag patients on methotrexate to the GP. We were unable to check relevant patient records on the day of our inspection because the member of staff proficient in searching the electronic case management system for the information we requested was away. Shortly following the inspection we were sent screenshots which

showed there were three patients on methotrexate, however we were not sent confirmation that each of these patients received regular monitoring in accordance with national guidance, as requested.

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. We saw sets of PGDs that had been updated in 2014. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role, as well as updates in diabetes which was a clinical area of expertise that she was developing.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors, however a system was not in place to log such incidents efficiently, review them promptly, take appropriate action to minimise the chance of similar errors occurring again, and then going back to check that the action had been effective.

Cleanliness and infection control

We observed the premises to be clean and tidy, and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Arrangements were in place for the segregation and disposal of clinical waste.

However, other elements of the Department of Health Code of Practice on the prevention and control of infections and related guidance were not in place. There were infection control policies and supporting procedures but these documents had not been customised to reflect the practice's arrangements. They did not provide staff with information and guidance that was immediately relevant to them. The practice nurse was the lead for infection control, however not all staff were aware of this. Staff had last completed infection control training in 2010. Cleaning checklists were posted in consulting rooms, however they were not being completed. The practice did not have cleaning schedules for the cleaner to follow that would ensure appropriate standards of cleanliness and infection

Are services safe?

prevention and control were maintained in each of the different clinical and non clinical areas within the practice. There had been no infection control audit within the last 12 months.

The practice had arrangements in place for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed there were regular checks to reduce the risk of infection to staff and patients.

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. A schedule of testing was in place and we saw evidence of calibration of relevant equipment.

Staffing and recruitment

The practice had a New Employee Recruitment, Selection, Interview & Appointment Policy & Protocol, however it had not been customised to reflect the practice's own arrangements. For example, it made no distinction between the recruitment of clinical and non-clinical staff. Records we looked at contained some evidence that recruitment checks had been undertaken prior to employment. However, none of the staff had been recruited since April 2013 when the regulation of staff recruitment came into force. The practice did not have a record of the locum GP's current professional indemnity details, although other relevant information was recorded.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff worked flexibly to ensure there were enough staff on duty at any one time. There was a locum GP who worked two sessions a week and a locum practice nurse to provide cover and additional capacity, for example when there was a drive to complete childhood immunisations or flu vaccinations. 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.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checking medicines and equipment to ensure they were fit for use. However, processes and policies were limited or were not in place to manage and monitor other risks, including for example significant event analysis, chaperone arrangements, and infection control.

Health and safety information was displayed for staff to see and there was an identified health and safety representative. A health and safety audit of the premises had been completed in 2015 and the practice had a designated responsible person for health and safety compliance.

The practice did not maintain a risk log to help the provider to understand the risks the practice faces and the likelihood of the risks occurring and impact on the practice, and to decide the appropriate actions to take to prevent or reduce risks.

Staff we spoke with were able to describe how they would identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies, although there were no formal written processes.

Arrangements to deal with emergencies and major incidents

The practice did not have arrangements in place to manage emergencies. Records showed that not all staff had received training in basic life support within the last 18 months, although training had been booked to take place later this year; and the practice was not equipped with oxygen and an automated external defibrillator (used in cardiac emergencies). The practice had a nebuliser (used to deliver high doses of asthma reliever medicines in an emergency). Not all staff knew the location of the nebuliser. It was in a locked cupboard in its original packaging and only the practice manager knew where the keys were. We were told there had never been an occasion for its use.

Medicines for the treatment of a range of medical emergencies, for example anaphylaxis, were easily accessible to staff in a secure area of the practice and all staff knew of their location. Anaphylaxis is a sudden allergic reaction that can result in rapid collapse and death if not

Are services safe?

treated. 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.

There was no risk assessment in place to support the provider's choices and omissions in respect of the equipment and medicines the practice kept to deal with medical emergencies.

There was an agreement between the practice and another practice in Newham that each could use the other's

premises in an emergency situation where their premises were unusable, for example in the event of fire or flood. There were no other business continuity plans in place to deal with emergencies that may impact on the daily operation of the practice, for example power failure, adverse weather, and unplanned absence.

The practice had carried out a fire safety compliance audit in 2015 that included actions required to maintain fire safety. Staff had not completed fire safety training nor had they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We discussed with the GP how NICE guidance was received into the practice. They told us they were signposted to new guidance by email which they then disseminated in practice and clinical staff meetings as necessary. The GP also regularly attended CCG cluster meetings where best practice, ideas and innovation were shared to improve delivery and provision of health services to patients, for example stroke prevention in patients with atrial fibrillation.

Staff described how they carried out comprehensive assessments which covered all health needs and was 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. However, the GP's electronic patient records in particular did not capture this in sufficient detail.

The GP told us they supported all staff to review and discuss new best practice guidelines, and clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice nurse prescriber was being supported to develop expertise in diabetes. There were fortnightly clinical meetings between the GP, practice nurse and healthcare assistant, and ad hoc meetings; however none of these were recorded in writing.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP and staff 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 people's 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 used to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last 18 months. Two related to improving the treatment for patients with type 2 diabetes and the third related to patients on sip feeds. Sip feeds are a kind of nutritional supplement. All three audits demonstrated that outcomes were improved through intensified review and monitoring and the better use of medicines; however none were completed audits in that a follow up check had not yet been completed to demonstrate that changes in practice resulting since the initial audit had become embedded.

We saw that clinical audits were linked to medicines management information or were undertaken as a result of information from the Quality and Outcomes Framework (QOF). 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. The diabetes-related audits were example of these. Medicines management had recommended a list of patients for whom a certain diabetic medication should be stopped, and records we looked at showed this had happened.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice's performance was comparable to national averages for all but one QOF clinical target, which related to blood sugar levels in patients with diabetes. We were told that sometimes it was hard to convince patients to go on to insulin, but the practice was trying to improve on this. Overall, the practice achieved 97.1% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for five out of the six diabetes related indicators was better than the national average.
- Performance for mental health related QOF indicators was better than the national average.
- The dementia diagnosis rate was comparable to the national average

Are services effective?

(for example, treatment is effective)

- The percentages of children receiving child immunisation at 12 months, 24 months and five years compared favourably with the Newham average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action being taken to address this, for example to improve blood sugar control in diabetic patients.

The team was making use of clinical supervision meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement, dedicating effort and time to reaching QOF targets.

The practice's prescribing rates were also similar to national figures, except for certain broad-spectrum antibiotics (Cephalosporins and Quinolones). We reviewed the notes of patients who were given these antibiotics, which showed the antibiotics had been prescribed in some situations appropriately, for example where the patient was allergic to other antibiotics; but not in other cases. The practice was aware of the need to reduce where possible the use of these antibiotics because of the risk of antibiotic resistance to public health.

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.

The practice had a palliative care register and there were regular multidisciplinary case review meetings where patients on the register were discussed to ensure their care and support needs and those of their families were being met.

Registers of patients with diseases and long term conditions such as diabetes, asthma, heart disease and cancer were kept to help the practice monitor the treatment and care these patients received, for example structured regular reviews. QOF data showed that almost all these patients had received their reviews. We saw that all but one cancer patient had received their review and we were told this was because the patient was mostly in hospital. The practice also kept a register of patients identified as being in vulnerable circumstances, for example people with learning disabilities, and a register of

carers. The practice had 11 patients who had chronic obstructive pulmonary disease (COPD), which was fewer than might be expected from national data. The practice was aware of this and we were told it was looking for more patients on their records who might have this condition.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with attending mandatory courses such as basic life support. The GP was up to date with their yearly continuing professional development requirements and had been revalidated. 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 performers list with NHS England. The GP attended a wide range of continuing professional development and education events. This was documented on his e-portfolio and signed off as part of his revalidation.

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 support for relevant courses where staff were interested. For example the healthcare assistant had completed NVQ Level 2 Health & Social Care training.

The practice nurse and healthcare assistant roles were clearly understood by staff. There was evidence they were trained appropriately to fulfil these roles. For example, the practice nurse had recently completed update training on asthma and diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of 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. Staff understood their responsibilities 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. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP attended the practice

Are services effective?

(for example, treatment is effective)

every day to complete this work. All staff we spoke with 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.

Emergency hospital admission rates for the practice were as expected at 11.08 per 1,000 population compared with the national rate of 13.06 admissions per 1,000 population. The GP told us that those patients who were frequent attenders to A&E were flagged up and spoken to. However, the GP could not show us documentation of these discussions. The practice was not commissioned for the unplanned admissions enhanced service.

The clinical commissioning group prescribing advisor came regularly to the practice to offer clinical staff their support and expertise. The diabetes specialist nurse ran clinics with the practice nurse at the practice every six weeks.

The GP told us patients with complex needs were discussed in multidisciplinary team meetings and CCG cluster meetings; and showed us an example of a care plan for a patient experiencing poor mental health.

Information sharing

The practice had systems to provide staff with the information they needed. An electronic patient record was available to staff to coordinate, document and manage patients' care. The software also enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Staff had been trained on the system. A few told us they were still getting to grips with all the things the system could do for the practice, but were comfortable using for their day to day work.

A referral book enabled the practice to keep track of patients collecting their choose and book referral letters, and patients who had not collected their letter were contacted.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004, and of their duties in fulfilling these Acts. All the 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. All clinical staff 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.

There was a practice policy for documenting consent for specific interventions. For example, parental consent was documented for child immunisations.

Health promotion and 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. For example,

Newham has the third highest number of diabetics in the UK, and the practice was working to further improve treatment and care for diabetic patients and offering pre-diabetes health check and healthy lifestyle interventions in line with Newham's Health and Wellbeing (HWB) Strategy.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 37.05% of eligible patients took up the offer of the health check.

The practice identified patients who needed additional support, and was proactive in offering additional help. For example it had identified the smoking status of 99% of patients with long term conditions and given support to 99% of these smokers to help them quit. Information about the quit rate amongst these smokers was not available to us, however.

The practice's performance for the cervical screening programme was 81.55%, which was similar to the national average of 81.89%. A practice nurse had responsibility for following up patients who did not attend.

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 similar to national / local averages for the majority of immunisations where comparative data was available. For example:

Are services effective?

(for example, treatment is effective)

- Flu vaccination rates for the over 65s were 81.93%, and for at risk groups 75.33%. These were similar to national averages.

Immunisation rates for the vaccinations given to children aged 12 months and 24 months ranged from 88.2% to 92.2%; and to five year olds, from 62.5% to 91.1%. These were comparable to CCG averages.

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 published 08 January 2015 and patient satisfaction questionnaires sent out by the GP to patients who had had joint injections (minor surgery) in 2014-15.

Evidence from these sources showed patients were satisfied with aspects of the care they received. For example, data from the national patient survey showed the practice performed in line with the Newham average for the following:

- 67.9% said the GP treated them with care and concern compared to the CCG average of 74.2% and national average of 82.7%.
- 46.0% said they always or almost always see or speak to the GP they prefer compared to the CCG average of 50.0% and national average of 60.0%.

The completion rate was 17%: 446 surveys were sent out and 78 surveys were sent back.

Twenty one out of 22 patients responded to the minor surgery satisfaction survey. The responses indicated a high degree of satisfaction with the GP, information given about the procedures, the time given to the procedure, and after care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards and the great majority were very positive about the service experienced. Patients described a service that was empathetic, sympathetic, professional and approachable. They found the service easily accessible, that staff were kind and caring, and that their privacy and dignity were respected. They commented that the premises provided a clean and safe environment and some stated that they received excellent support for long term conditions. Many clearly valued their family GP of many years standing.

Two comments were less positive and said that waiting times to be seen could be too long, with the doctor running late. However these were accompanied by comments about the doctor's willingness to address more than one problem during a consultation and about the doctor being thorough.

We also spoke with two patients on the day of our inspection. One was very satisfied with the treatment and care received and one was not.

We spoke with members of the patient participation group, and it was clear from them and from the GP that the GP tried to offer all patients appointments where possible and was very much involved in the care and wellbeing of his patients.

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.

We saw that staff were careful to ensure patients' confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. The waiting area was separate from the reception desk and this prevented patients overhearing potentially private conversations between patients and reception staff. We received many comments about reception staff being helpful and polite. In the national patient survey, 71% said the receptionists were helpful performing in line with the CCG average of 81.4% and the national average of 86.9%.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 in line with local and national averages in these areas. For example:

- 71.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 77.3% and national average of 82.0%.

Are services caring?

- 65.1% said the GP was good at involving them in decisions about their care compared to the CCG average of 69.8% and national average of 74.6%.
- 61.9% said the nurse GP was good at involving them in decisions about their care compared to the CCG average of 61.4% and national average of 66.2%.

Patient feedback on the comment cards we received indicated patients felt the GP took good care of them, and that they were provided with all the treatment and support they needed. Many patients described the GP as very hardworking and very caring.

Staff were able to meet the language needs of the majority of patients on its list. Staff told us interpreter services were available where this was not the case.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the GP and rated it in line with local and national averages. The information was less positive about the emotional support provided by the nurse. For example:

- 67.9% said the GP treated them with care and concern compared to the CCG average of 74.2% and national average of 82.7%.
- 60.2% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 67.2% and national average of 78.0%.

The comment cards we received highlighted that staff responded compassionately when patients needed help, and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was signposting information in the waiting area to support services for carers.

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 the practice served a predominantly Asian population and had the language skills amongst its staff to communicate with many patients in their first language.

We were told the GP engaged regularly with the CCG monthly cluster meetings where ideas and innovation were shared to improve delivery and provision of health services to patients. For example the practice's work to improve diabetes prevention, as well as treatment and care was supported by initiatives and service developments led by the CCG.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the 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.

For example, an action plan was in place to reduce waiting times for appointments due to the GP running late. This included patient education and time management training for the GP.

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 given to patients who needed them. Staff were able to meet the language needs of the majority of the practice population, but access to interpreter services was available if needed. There was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of some people with disabilities. The practice was accessible to patients with mobility difficulties as there was a lift to the facilities on the upper level. 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 plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There were no female GPs in the practice. The practice leaflet clearly stated that this was a lone GP practice with limited capacity for meeting patient gender preferences for medical care.

Access to the service

The surgery's opening hours were:

- Monday, Tuesday and Friday – 8.00am to 6.30pm
- Wednesday – 8.00am to 8.30pm
- Thursday – 8.00am to 2.00pm

Appointments were available:

- Monday – between 10.00am to 1.30pm and 4.00pm and 6.30pm
- Tuesday – between 8.00am to 9.30am, 10.00am to 1.30pm, and 4.00pm to 6.30pm
- Wednesday – between 8.00am to 9.30am, 10.00am to 1.30pm, 4.00pm to 8.30pm
- Thursday – between 8.00am to 9.30am and 10.00am to 1.30pm
- Friday – between 8.00am to 9.30am, 10.00am to 1.00pm, and 5.00pm to 6.30pm

These appointments included routine appointments booked up to two weeks in advance and urgent same-day appointments.

Comprehensive information was available to patients about appointments in the practice leaflet. This included how to arrange urgent appointments and home visits, and how to book appointments online. There were also arrangements to ensure patients received urgent medical 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. Information on the out-of-hours service was provided to patients.

The national patient survey information we reviewed showed patients responded positively to some questions about access to appointments. For example:

- 75% were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.

Are services responsive to people's needs?

(for example, to feedback?)

- 54% generally found it easy to get through to someone at the surgery on the phone as good compared to the CCG average of 71% and national average of 74%.
- 48% described their experience of making an appointment as good compared to the CCG average of 65% and national average of 74%.
- 80% said they last appointment they go was convenient compared to the CCG average of 86% and national average of 92%.

Areas for improvement included:

- 31% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 51% and national average of 65%.
- 15% felt they don't normally have to wait too long to be seen compared to the CCG average of 42% and national average of 58%.

An action plan was in place to address these survey findings.

Comment cards we received showed that patients were nonetheless satisfied with the appointments system in general because they felt once they were with the GP they were being given the treatment and care they needed. Many expressed appreciation that the GP would do their very best to see them as soon as possible, and were seen on the same day of contacting the practice when needed. Staff told us all patients were seen within 48 hours unless they chose to book an appointment further in advance. Routine appointments were available for booking two weeks in advance.

Patients were helped to access the service in different ways depending on their needs, for example:

- Home visits were available for older people and people with long-term conditions who were unable to visit the practice.
- Appointments were available outside of school hours for children and young people. The waiting area provided a child- friendly and safe environment.

- Extended opening hours, online booking and repeat prescription systems and telephone consultations where appropriate were of benefit to working age people in particular.

It was the practice's policy to formally designate some appointment slots longer than others, for example to meet the needs of older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions who may need this additional time. However, feedback from comment cards and from the patient participation group demonstrated an understanding that the GP will take longer with certain patients as necessary, even if this means he then runs late.

Listening and learning from concerns and 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 to help patients understand the complaints system. It was set out in the practice leaflet. Further information about the complaints process was included in the response template letter the practice used, for example advice to the patient about what to do if they were not satisfied with the response to their complaint.

We looked at the one complaint the practice had received in the last 18 months and found the complaint had been investigated thoroughly and responded to in a timely way. Lessons learned had been acted on and improvements made to the quality of care as a result: the appointment booking system had been reviewed and reception staff had received additional training in communications with patients.

Are services well-led?

Inadequate 

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

Our findings

Vision and strategy

The practice had aims and objectives to deliver high quality care and promote good outcomes for patients. We found details of the aims and objectives in the provider's Statement of Purpose. The provider had established the practice some 30 years ago and he and his staff were proud of what they had achieved. The provider had considered going in to partnership with another GP but currently had no plans to change from being a lone GP practice.

The practice's aims and objectives included:

- Offering professional care and advice to patients.
- Promoting health and wellbeing working in partnership with patients, their families, and carers.
- Listening to and supporting patients with respect so they can have choice to be able to live independent lives.
- Working in partnership with other professionals in the care of our patients

We spoke with three members of staff and they all demonstrated commitment to the aims and objectives of the practice. We observed them carrying out their roles and responsibilities in keeping with the practice's aims and objectives.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, the practice manager was the lead for complaints and the GP was the lead for safeguarding. We spoke with four members of staff and they were all 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 practice held formal staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed. These meetings were intended to take place once a month, however there had been one meeting only in the six months prior to our inspection. Nevertheless, staff we spoke with felt involved and included in the operation of the practice and the services it provided.

The practice used QOF data to measure its performance and this showed that it was performing in line with national standards. We also saw that designated clinical and non clinical staff worked together to produce and deliver action plans to maintain or improve outcomes.

Information from complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction, and action had been taken in response to feedback from patients or staff.

However, some other of the practice's governance arrangements required improvement. The practice had a number of policies and procedures in place to govern activity and these were available to staff, but not all of them had been customised to reflect the practice's own arrangements, for example the infection control policies and procedures. This limited their usefulness in providing guidance and direction to staff. There was no system in place to provide assurance that staff had read any of the policies.

The practice did not have an on-going programme of clinical audits to monitor quality and systems to identify where action should be taken.

Complete records in respect of the care and treatment provided to each patient and of decisions taken in relation to the care and treatment provided were not maintained. We looked at the records of eight patient consultations that took place on the morning of 08 June 2015. None of them provided a complete record of the consultation. For example one record recorded only the presenting problem and the medicine that had been prescribed. Others showed only the investigation(s) ordered, but no clinical information behind it. Some of the records did not have any information, so it was not clear if the patient was seen. None of the records recorded the relevant history or special precautions given to patient, although the GP was able to provide us with this information verbally.

The practice had no method of identifying, recording and managing risks, for example through significant event analysis. No formal risk assessments had been carried out, for example to justify the provider's decision not to equip the practice with an automated external defibrillator (AED). The practice did not maintain a risk log.

Leadership, openness and transparency

Are services well-led?

Inadequate 

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

The GP was visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff felt involved in discussions about how to run the practice and how to develop the practice: the GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Records showed that team meetings had been held almost every month in 2014. However, there had been one meeting only in the six months prior to our inspection in June 2015. Staff indicated that there was an open culture within the practice and felt able to raise any issues at team meetings, confident in doing so, supported if they did. Staff said they felt respected, valued and supported, particularly by the GP and practice manager.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the PPG, surveys and complaints received. It had an active PPG which included representatives from various population groups including people from minority ethnic backgrounds and in the working age and older people age groups. The practice recognised that people aged under 25 years were under represented on the group, but their efforts to get more younger adults to join had not been successful. The practice (with the PPG) had completed local

surveys in the three years to 2013-2014 and an action plan was in place to improve waiting times and telephone access to the practice. We spoke with six members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

We also saw evidence that the practice had reviewed results from the national GP survey to see if there were any areas that needed addressing. These coincided with the findings of the practice's own local surveys.

In these ways, the practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through informal and formal meetings and discussions. Staff told us they felt comfortable giving feedback and discussing any concerns or issues with colleagues and management. They told us they felt involved and engaged in how the practice improved outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three 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.

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

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Care had not been designed to meet patients' needs in medical emergencies. The practice did not have oxygen available and staff had not received basic life support training within the last 18 months. Regulation 9.-(3)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Risks to the health and safety of patient receiving care and treatment had not been assessed. The practice did not have an automated electronic defibrillator (AED). The practice sometimes relied on the practice nurse or a female GP colleague from another practice to perform clinical examinations on patients who did not want the male GP to examine them. Risks assessments were not in place to demonstrate these were safe ways of providing care and treatment for patients. Regulation 12.-(2)(a)

The practice was not doing all that is reasonably practicable to mitigate risks. There were no business continuity plans in place to deal with emergencies that may impact on the daily operation of the practice other than fire or flood; for example power failure, adverse weather, and unplanned absence. Staff had not completed fire safety training nor had they practised regular fire drills. Regulation 12.-(2)(b)

The practice was not assessing the risk of, and preventing, detecting and controlling the spread, of infections. There were infection control policies and supporting procedures but these documents had not been customised to reflect the practice's arrangements. The practice nurse was the lead for infection control, however not all staff were aware of this. Staff had last

Requirement notices

completed infection control training in 2010. Cleaning checklists and cleaning schedules were not in use. There had been no infection control audit within the last 12 months. Regulation 12.-(2)(h)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Systems were not established to prevent abuse of patients. Non-clinical staff that may be called up to perform chaperone duties had not been DBS checked. Regulation 13.-(2)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems or processes were not in place to ensure compliance with the requirements in this Part. The GP was providing joint injections for the treatment of arthritis but was not registered with CQC to carry on the regulated activity of Surgical procedures. Regulation 17.-(1)

Systems were not in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk. The practice had no method of identifying, recording and managing risks, for example through significant event analysis and a risk log. Regulation 17.-(2)(b)

Processes were not in place to maintain a complete record in respect of each patient, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. Amongst the patient records for recent consultations we looked at, one recorded only the presenting problem and the medicine that had been prescribed, and some others showed only the investigation(s) ordered, but no clinical information behind it. Some of the records did not have any information, so it was not clear if the patient was

This section is primarily information for the provider

Requirement notices

seen. None of the records recorded the relevant history or special precautions given to patient, although the GP was able to provide us with this information verbally.
Regulation 17.-(2)(c)

Other records as are necessary were not maintained. For example discussions in clinical meetings within the practice in Newham cluster meetings were not recorded.
Regulation 17.-(2)(d)(ii)