

The Sorsby Medical Practice

Quality Report

3 Mandeville Street

London

E5 0DH

Tel: 020 8986 5613

Website: www.sorsbymedicalpractice.nhs.uk

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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

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	7
What people who use the service say	11
Areas for improvement	11

Detailed findings from this inspection

Our inspection team	12
Background to The Sorsby Medical Practice	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	14
Action we have told the provider to take	32

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Sorsby Medical Practice on 19 February 2015.

Overall the practice is rated as Good. The practice is run by the Lower Clapton Group Practice nearby, which is separately registered with the Care Quality Commission and was not visited as part of this inspection.

Specifically, we found the practice to be good for providing, effective, caring, responsive and well-led services. It was also good for providing services to the six population groups we looked at: 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; and people experiencing poor mental health (including people with dementia).

We found the practice requires Improvement for providing safe services.

Our key findings were as follows:

- The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment.
- The practice promoted good health and prevention and provided patients with suitable advice and guidance.
- The practice had several ways of identifying patients who needed additional support, and was pro-active in offering this.
- The practice provided a caring service. Patients indicated that staff were caring and treated them with dignity and respect. Patients were involved in decisions about their care.
- The practice provided appropriate support for end of life care and patients and their carers received good emotional support.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.

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

Summary of findings

Importantly, the provider must:

- Ensure patients are fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out and recorded prior to a staff member taking up post.

In addition the provider should:

- Ensure the records of child protection training are available for all staff.
- Arrange for all staff to complete formal training in safeguarding of vulnerable adults.
- Take steps to communicate the practice's chaperone policy more clearly to patients in clinical areas.
- Ensure the recommendations of the recent PHE report on cold storage of medicines are implemented and the policy for ensuring medicines are kept at the required temperatures is followed at all times.

- Arrange infection control update training for all staff who need this and ensure records are available for staff who have completed the training.
- Implement a planned schedule of fire evacuation drills and arrange fire safety update training for all staff.
- Review the practice's consent protocol to ensure mental capacity is appropriately taken into account.
- Continue to pursue action to make further improvements in disabled access to the practice.
- Take further steps to address dissatisfaction raised by patients about continuity of care, access to appointments and waiting times.
- Arrange for information about the complaints procedure to be made more readily available to patients in the waiting area; and review the procedure document to ensure references to other agencies is up to date and accurate.
- Ensure the practice's whistleblowing policy is up to date and staff are made aware of it.

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. Systems and processes were not always implemented well enough to ensure patient safety.

The majority of staff had undergone recent safeguarding children training but details were not available to confirm the training undertaken by nursing staff. Two GPs and two administrative staff had undertaken formal training in safeguarding of vulnerable adults. However, records were not available to confirm whether the rest of staff had undertaken such training. There was a chaperone policy, which was visible on the waiting room noticeboard but was not displayed in all consulting rooms we visited.

The policy for ensuring medicines were kept at the required temperatures was not always followed and we identified potential breaches. Following the inspection the practice raised this as a clinical incident with the local Public Health England (PHE) Health Protection team. The PHE investigated the incident and their report contained a number of recommendations to prevent a recurrence, including staff training and robust auditing which the practice was following up.

The practice's infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Regular infection control audits took place and the practice acted on the outcomes. However, for all but one member of staff, no details were available about the most recent infection control training undertaken by staff.

There were shortcomings in the practice's recruitment processes in particular regarding documentary evidence of pre-employment checks, including those for locum staff.

There were annual fire risk assessments but there had been no fire evacuation drills since 2012. Staff received appropriate fire safety instruction during induction but periodic update training had not been provided.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. The practice scored positively in their QOF performance and used QOF to steer practice activity. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely.

Good



Summary of findings

Patient's needs were assessed and care was planned and delivered in line with current legislation. The practice participated in clinical audit and routinely collected information to review and improve patient care and outcomes. The practice worked in collaboration with other health and social care professionals to provide a multidisciplinary approach to their care and treatment. The practice had a consent protocol which staff were aware of and followed. The protocol did not make reference to the Mental Capacity Act 2005 with regard to mental capacity and "best interest" assessments in relation to consent. However, we found clinical staff were aware of the Act with regard to consent. There were appropriate arrangements in place to support staff appraisal, learning and professional development, although there were some gaps in evidence of training staff had received. The practice promoted good health and prevention.

Are services caring?

The practice is rated as good for providing caring services. Data from the national GP patient survey showed the practice was rated broadly in line with the CCG average for dignity and respect, although views were more mixed about involvement in decisions and support in their care and treatment. Feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect and involved them in decisions about their care and treatment. We observed during the inspection that staff treated patients with kindness and respect, and maintained confidentiality. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Patients we spoke with felt the practice met their healthcare needs, and in most respects they were happy with the care provided. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments, but acknowledged this was a challenge when set against the need to provide urgent appointments. The premises and services had been adapted to meet the needs of people with disabilities. However, the practice recognised that disabled access could be improved. Regional NHS funding had previously been identified to improve access and make other improvements to the building but this was now uncertain. The practice acknowledged there was continuing dissatisfaction with the

Good



Summary of findings

appointments system despite significant changes made to improve the system. Further action to address this was in hand. There was an effective complaints system, although information about the complaints procedure was not readily available to patients in the waiting area.

Are services well-led?

The practice is rated as good for being well-led. The practice had a clear ethos which involved putting patients first and was committed to providing them with the best possible service. The practice's aims were set out in its statement of purpose, practice leaflet and website and staff were committed to these aims. There were governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The practice had a range of policies and procedures to govern activity which were regularly reviewed. There was a clear leadership structure with named members of staff in lead roles. There was an open culture, staff were clear about their own roles and responsibilities and felt supported in their work. There were arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Staff had received induction training and regular performance reviews. The practice proactively sought feedback from staff and patients, including a patient participation group (PPG), which it acted on. The practice had a whistleblowing policy but not all staff we spoke with were aware of the policy.

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. The practice held monthly multidisciplinary team meetings to discuss patients with complex needs including elderly and frail patients and those with end of life care needs. All patients aged over 75 were offered an annual health check. They also had care plans which were actively added to and amended as circumstances changed. For older patients and patients with long term conditions home visits were available if required. Flu vaccinations were provided to older people in at-risk groups. The practice attended 'One Hackney Quadrant' meetings to support priority groups of patients, focusing mainly on over 75s with complex needs who needed a special type of rapid response when their condition deteriorated to enable them to remain supported in the community, including people at the end of life. Older patients had access to a bypass number for the practice so they could readily access a duty doctor and local healthcare services. There were effective arrangements in place to support carers.

Good



People with long term conditions

The practice is rated as good for the care of people with long term conditions. Under a local enhanced services scheme the practice carried out monthly monitoring of progress focusing on patients with long term conditions. Structured annual reviews were undertaken for patients with long term conditions, including diabetes, COPD, and heart failure. There were care plans in place for these patients. The practice liaised with other services to enable people with long term conditions to remain in their homes. The practice provided a range of services for patients with chronic health problems. For diabetes they invited patients for a detailed yearly check-up with an initial appointment with a healthcare assistant. There were practice based clinics run by a diabetic specialist (twice weekly), a diabetic dietician (monthly), and heart failure nurses (monthly). Diabetic patients requiring dietary advice were referred to the monthly diabetic dietician clinic. The practice kept a register of patients identified as being at high risk of admission to hospital, including patients with long term conditions.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were procedures in place to safeguard children and young people from abuse and the majority of staff had received appropriate training. There were monthly meetings with a health

Good



Summary of findings

visitor and named midwife to review at risk children. These meetings were also used to discuss patients at risk of or experiencing postnatal depression and cases were referred to peri-natal services. The practice attended multidisciplinary meetings to review high risk pregnancies including related obesity. The practice provided a contraception, family planning and sexual health service. The practice ran antenatal and post natal care clinics and there was a weekly 'well baby' clinic. The practice offered screening for sexually transmitted diseases (STDs). All women were encouraged to attend for regular cervical smear testing and the practice had a reminder system for patients who did not attend. The practice offered a full range of immunisations for children. The practice advertised and referred patients to City and Hackney Young People's Services (**CHYPS**) Plus (a sexual and mental health service for young people). The practice also promoted the local First Steps psychology service, a counselling service for children, young people and their families who have mild to moderate mental health problems; and the Child and adolescent mental health services (**CAMHS**), for children aged 0-18 and their families who are experiencing mental health problems.

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 practice was accessible to working people. For example, the practice provided a clinic from 6.30pm to 8.00pm on Monday and 7.00am to 8.00am on Tuesday. Appointments could be booked on line and repeat prescriptions ordered electronically. A health check was offered to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. This included a free cardiovascular and diabetes risk assessment and advice on how to reduce the risk. Where appropriate patients were referred to a local exercise referral scheme, which provided supervised exercise sessions for people with a range of conditions including those with or at risk of coronary heart disease, diabetes, mild to moderate depression and obesity. The practice identified the smoking status of patients over the age of 16 and facilitated access to a local smoking cessation service for advice on quitting smoking. Flu vaccinations were offered to patients aged 65 and older and the practice provided travel vaccinations and advice.

Good



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 kept registers of patients with learning disabilities and mental health problems to enable their care and treatment needs to be kept under

Good



Summary of findings

review. These patients (including those with dementia) were supported to make decisions through the use of care plans, which they were involved in agreeing. Patients with a learning disability were provided with an easy read care plan in a pictorial format. The practice had links with local services such as Hackney Law Centre and local food banks to support vulnerable people. The practice also facilitated 'in-house' access to benefits and welfare advice through the Citizen's Advice Bureau (CAB) and Family Action and the social prescribing for health scheme to improve the health of isolated over 50s and people with type 2 diabetes. The practice followed "Once for London" Pan-London principles of registration and did not request documentation so as not to disadvantage any patients. The practice had long historical links with the local traveller community and was aware of their needs as a community and their often complex social and family circumstances. The practice offered all new patients a new patient HIV test at registration. Staff knew how to recognise signs of abuse and the process to follow in the event of any safeguarding concerns. However, only a few staff had been trained in safeguarding of vulnerable adults. If needed, translation services were available for patients who did not have English as a first language. The premises and services had been adapted to meet the needs of people with disabilities. Regional NHS funding had previously been identified to improve access and make other improvements to the building but this was now uncertain.

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 monitored repeat prescribing for people receiving medication for mental ill-health and undertook reviews when repeat limits were reached. There was a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups including patients with mental health problems. Clinical staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. However, the practice's consent protocol did not make reference to the Act with regard to mental capacity and "best interest" assessments in relation to consent. There were monthly psychiatric liaison clinics with case discussion beforehand and subsequent email advice services. The practice also worked closely with a local psychotherapy service to support patients who were frequent attenders; had medically unexplained symptoms; hard to engage groups and those with personality disorders. In addition the practice had active links with the primary care psychology 'Improving Access to Psychological Therapies' (IAPT) programme which provided self-help courses for patients with common mental health

Good



Summary of findings

difficulties such as stress, worry and low esteem. The practice promoted and facilitated patient access to 'the big white wall', an on-line emotional health support forum for people with mental health problems.

Summary of findings

What people who use the service say

We received 14 completed Care Quality Commission (CQC) comments cards providing feedback about the service. On the day of our inspection we also spoke with 11 patients, including three representatives of the practice's patient participation group (PPG). Patients said they felt the practice offered a good or excellent service and staff were polite, efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. One commented that sometimes there were no nurses and another was unhappy about repeat prescriptions. We also spoke with 11 patients on the day of our inspection, including three members of the PPG. The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some comments were less positive, including lack of time with the GP, and the need for some GPs "to improve their bedside manner."

In the national patient survey 2014/15 patients views were mixed. Whilst in some respects they were broadly

satisfied with their treatment, scores were generally below CCG and national averages for satisfaction in consultations with doctors and nurses, emotional support, access to appointments and waiting times and continuity of care. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included the employment of a new receptionist to help answer phone calls and reduce queues in reception; on-line appointment access to take pressure off the telephones; improvements in confidentiality at the front desk while discussing confidential information with the patients and advertising that appointments were 10 minutes in length; review of the comments form for patients to put in the comments box and making it available at all times in the waiting room; and asking patients to join the PPG at registration at new patient health checks.

Areas for improvement

Action the service **MUST** take to improve

- Ensure patients are fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out and recorded prior to a staff member taking up post.

Action the service **SHOULD** take to improve

- Ensure the records of child protection training are available for all staff.
- Arrange for all staff to complete formal training in safeguarding of vulnerable adults.
- Take steps to communicate the practice's chaperone policy more clearly to patients in clinical areas.
- Ensure the recommendations of the recent PHE report on cold storage of medicines are implemented and the policy for ensuring medicines are kept at the required temperatures is followed at all times.

- Arrange infection control update training for all staff who need this and ensure records are available for staff who have completed the training.
- Implement a planned schedule of fire evacuation drills and arrange fire safety update training for all staff.
- Review the practice's consent protocol to ensure mental capacity is appropriately taken into account.
- Continue to pursue action to make further improvements in disabled access to the practice.
- Take further steps to address dissatisfaction raised by patients about continuity of care, access to appointments and waiting times.
- Arrange for information about the complaints procedure to be made more readily available to patients in the waiting area; and review the procedure document to ensure references to other agencies is up to date and accurate.
- Ensure the practice's whistleblowing policy is up to date and staff are made aware of it.

The Sorsby Medical 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 and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. The GP and expert by experience were granted the same authority to enter the practice as the CQC inspector.

Background to The Sorsby Medical Practice

The Sorsby Medical Practice provides primary medical services through a General Medical Services (GMS) contract to around 4665 patients in the City and Hackney area of London. The practice is part of the City and Hackney Well Consortium of GP practices. The practice has been in temporary management by Lower Clapton Group Practice, a larger nearby practice, since April 2010. The contract to manage the practice permanently was won by Lower Clapton in early 2014. The date for contract signing has yet to be finalised but the practice anticipated this being in the near future. The practice has an ethnically diverse patient population, including 50% African/ Caribbean/ Black British; 30% White British/ White Other; 10% Turkish; and 10% Asian. Four point seven percent of the population is over age 75 compared to a national average of 7.6%, and is the fourth highest in the CCG area. There are very high rates of deprivation within the CCG area.

The practice is registered to carry on the following regulated activities: Diagnostic and screening procedures; Family planning; Maternity and midwifery services; Surgical procedures; and Treatment of disease, disorder or injury.

The practice applied for funding for redevelopment of the premises to improve facilities generally and disabled access in particular but the reorganisation of the NHS took place before this could be considered. At the beginning of 2015 the practice submitted a new funding bid to NHS England but there had been no decision on this at the time of the inspection.

The practice team is made up of a team of two GP partners (one female and one male), and five salaried GPs (all female). The practice employs a practice manager, reception manager, two nurses, two health care assistants, plus reception and administrative staff, including a notes summariser.

The practice occasionally teaches medical students and nurses but there were no trainee placements at the practice at the time of our inspection

The practice was open from 8.00am to 8.00pm on Monday; 7.00am to 6.30pm on Tuesday; and 8.00am to 6.30pm on Wednesday to Friday. Appointments were available from 8.30am to 11.30am, 3.00pm to 6.00pm and 6.30pm to 8.00pm Monday; 7.00am to 8.00am, 8.30am to 11.30am and 3.00pm to 6.00pm on Tuesday; and 8.30am to 11.30am and 3.00pm to 6.00pm on Wednesday to Friday.

There are arrangements to ensure patients receive urgent medical assistance when the practice is closed. Out of hours services are provided by a local provider. If patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on the circumstances. Information is also provided to patients on the 'out of hours' service on the practice's website and in the practice leaflet. They are

Detailed findings

advised they will be put through to the 'out of hours' service who will take details of the problem and pass these to the doctor, who will phone them back as soon as possible.

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.

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 we hold about the practice and asked other organisations to share what they knew. We liaised with City and Hackney Clinical Commissioning Group (CCG), Healthwatch Hackney and NHS England.

We carried out an announced visit on 19 February 2015. During our visit we spoke with 11 patients and a range of staff including four GPs, a nurse and health care assistant, the practice manager, and reception staff. We reviewed 14 comments cards where patients who visited the practice in the week before the inspection gave us their opinion of the services provided. We observed staff interactions with patients in the reception area. We looked at the provider's policies and records including, staff recruitment and training files, health and safety, building and equipment maintenance, infection control, complaints, significant events and clinical audits. We reviewed personal care plans and patient records and looked at how medicines were recorded and stored.

Are services safe?

Our findings

Safe track record

The practice 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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an abnormal blood test result was emailed to one of the GPs who was on a week's annual leave and was not checked by another GP during this time. The patient was contacted on day of the GP's return and admitted to hospital through A&E on same day. As a result of this incident a 'buddy system' was set up through the practice's computer system for checking results received by email of GPs on leave, backed up by a daily check by reception. The learning from the incident was communicated throughout the practice to ensure both clinical and non-clinical staff were aware of the new checks put in place to avoid a recurrence.

We saw evidence of incident reports documented for the last nine years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records of significant events and a summary was made available to us before the inspection for events that had occurred during the last year. These records provided a description of the nature of each event and the learning points identified. Staff we spoke with told us the outcomes of significant events were discussed with them. We were told also that any significant events would be discussed at practice meetings and lessons learned communicated. We saw evidence of this in the minutes of practice meetings we looked at and such events were a permanent item on the agenda of these meetings. There were weekly business meetings and monthly meetings to review specific areas including significant events.

The practice had an incident reporting policy and procedure which included a comprehensive incident reporting form. The forms were available on the practice computer system and staff sent completed forms to the

practice manager in the first instance for review. We saw records were completed in a comprehensive and timely manner and included details of outcomes and action taken. For example, abnormal cells were detected on a patient's smear test, which required a referral for colposcopy, an examination to check for signs of cervical cancer. The GP who received the test results misinterpreted the wording of the report and had thought that it had already been referred to colposcopy so took no further action. The error was picked up four weeks later, the patient informed and a colposcopy referral activated. NHSE was informed of the incident and it was discussed in a team meeting where the smear test policy was reviewed and GPs reminded of their responsibility to take any action highlighted by tests. A procedure was subsequently implemented to ensure patients were properly coded and any new female patients aged 25 or over had their smear history checked. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). There was a nominated GP lead responsible for reviewing and any distributing alerts and guidelines to staff within the practice by email. Alerts and guidance were also discussed at the practice's weekly clinical meetings and monthly education sessions.

Reliable safety systems and processes including safeguarding

The practice had appropriate safeguarding policies in place for both children and vulnerable adults, including contact details for local safeguarding agencies. The practice had nominated GP leads for safeguarding of both children and vulnerable adults and staff we spoke with knew who the lead was, how to recognise signs of abuse and the processes to follow. Staff training data indicated that the majority of clinical and non-clinical staff had undergone safeguarding children training at Level 3 which met with national guidance. The nurse we spoke with told us she had completed both classroom based and on line Level 3 safeguarding children training. However, records were not available to confirm the training undertaken for either of the two nursing staff. We were told that one of the administrative staff had received child protection training

Are services safe?

nine months ago, prior to joining the practice. In addition training was being arranged for a recently recruited receptionist. The training data we were shown indicated that two GPs and two administrative staff had undertaken formal training in safeguarding of vulnerable adults. Records were not available to confirm the training undertaken by the rest of staff. However, one of the GPs was a former safeguarding adults lead for the local CCG and provided relevant advice, instruction and support to all clinical and non-clinical staff.

There was a system to highlight vulnerable patients on the practice's electronic records and the practice kept 'at risk registers' for both children and vulnerable adults. There were monthly meetings with named health visitors and a named midwife to review at risk children and families and pregnant women where there were concerns. In addition the practice promoted the London Borough of Hackney NIA (a Swahili word which **means** 'purpose') project which offers support and advice for women and children suffering from domestic violence and all staff had participated in Identification and Referral to Improve Safety (IRIS) a general practice-based **domestic violence** and abuse training support and referral programme.

There was a chaperone policy, which was visible on the waiting room noticeboard but was not displayed in all consulting rooms we visited. (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). We were told some reception staff occasionally acted as a chaperone if nursing staff were not available. All those acting as a chaperone had undergone training and a criminal records check. Administrative staff who occasionally acted as a chaperone had received briefing about the role at the practice and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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. Practice staff, were aware of the action to take in the event of a potential power failure or where required temperatures were exceeded. However, we saw that some records did not reflect the action that was described to us when temperatures had gone outside the required range. Immediately after the inspection the practice raised the

matter as a significant event and contacted the local NHS England Health Protection Team for further support and advice, with reference to national guidance from Public Health England (PHE) on vaccine storage. The PHE investigated the incident and their report contained a number of recommendations to prevent a recurrence, including additional staff training and robust auditing of compliance with policy and procedure.

The practice nurses were not qualified as nurse prescribers, so patient group directions (PGDs) were in place in line with legal requirements and national guidance. PGDs allow specified health professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. All the necessary PGDs were signed as required and a folder was kept containing up to date directives. We saw, for example, PGDs for 2014 covering vaccinations for Hepatitis A, Typhoid, Shingles, Influenza and Meningitis C.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Regular reviews and medicines management plans were in place for those patients. There were a range of protocols to support appropriate medicines management including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis and mental health conditions. In the last year the practice had completed audits of prescribing of high risk medicines and had taken follow up action based on the outcomes.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and under the practice's prescription security profile were kept securely at all times.

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. No controlled drugs were kept at the practice.

Cleanliness and infection control

We observed the premises to be clean and tidy and a comprehensive cleaning schedule was in place. Cleaning

Are services safe?

services were provided and managed by NHS Property Services and their manager and supervisor carried out regular cleaning audits accompanied by the practice manager. They also completed monthly spot checks and provided written reports of their findings to the practice manager. Patients we spoke with raised no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and under the infection control policy were required to receive annual updates. However, for all but one member of staff, no details were available about the most recent training undertaken by staff.

The practice's infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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.

Regular infection control audits took place and the practice acted on the outcomes. For example, following an audit in December 2014 a programme of refurbishments was put in place to meet Department of Health requirements including replacing of carpets and fabric covered chairs in clinical rooms, and the replacement of sinks.

The landlords of the practice premises were responsible for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). They contracted a specialist company to carry out regular Legionella checks. We saw the report of the latest survey completed in May 2014.

Clinical waste was stored appropriately and a contract was in place for its collection and disposal.

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 which was 15 February 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment dated 26 January 2015; for example weighing scales, spirometers, blood pressure measuring devices, nebulisers, defibrillator and pulse oximeters.

Staffing and recruitment

We were told checks undertaken before staff began work included checks for relevant qualifications and training, professional registration, identity, criminal records, permission to work in the UK, and references. However, we reviewed the recruitment records of four administrative staff and found no evidence of criminal records checks for three of these staff and no reference checks for two of them. We were told that DBS checks had not been undertaken for all administrative staff, but the practice had not documented the rationale for not checking these staff.

At the time of the inspection the practice was employing a locum doctor through a locum agency. We were told that the practice sought information from the locum agency to show that these staff were suitably qualified, skilled and experienced and all appropriate pre-employment checks had been carried out. However, documentary evidence of this was not available at the inspection.

We were told that all staff received a comprehensive induction as part of the recruitment process. We saw evidence of this for a recently recruited member of staff who confirmed they had followed an induction process and been provided with a clear job description which had been effective in helping them take on their new role.

There were arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. This was done jointly for the practice and the Lower Clapton Group Practice. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice told us that the recruitment of clinical staff had been a challenge, due in part to

Are services safe?

uncertainty while the contract to run the service long-term by the Lower Clapton Group Practice was being resolved. However, at the time of our inspection the practice was interviewing for both doctors and nursing staff. Staff we spoke with told us that nurse staffing had been under resourced but this was now improving and additional support was also anticipated from nursing staff at the Lower Clapton Group Practice.

Monitoring safety and 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 building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice also had a combined health and safety policy and risk assessment. We saw the latest risk assessment of the practice completed on 2 February 2015. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

The practice used a risk profiling and stratification tool to search for and review frequent attenders to the practice and liaised with a local NHS acute trust and the City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) to secure appropriate referrals and treatment. Under a local enhanced services scheme the practice carried out monthly monitoring of progress focusing on patients with long term conditions including diabetes, heart failure, chronic obstructive pulmonary disease (COPD) and asthma, hypertension, cholesterol and atrial fibrillation. The practice monitored repeat prescribing for people receiving medication for mental ill-health and undertook reviews when repeat limits were reached. There were monthly meetings with a health visitor and named midwife to review at risk children. These meetings were also used to discuss patients at risk of or experiencing postnatal depression and cases were referred to peri-natal, mental health and specialist bereavement services.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we looked at showed that all staff had received training in basic life support apart from a recently recruited receptionist for whom arrangements for training were in hand. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Staff we spoke with knew the location of this equipment. We saw that the equipment was operational and we reviewed the records which confirmed that it was checked regularly.

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 and hypoglycaemia. Processes were also 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.

An up to date business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included loss of the surgery building, computer system, patient records, telephone and utilities, alarm systems and incapacity of staff. It also provided key staff and supplier contact numbers and a communication cascade flow chart. In the event of major disruption to the service, the plan made provision for the transfer of communications and temporary surgeries to the Lower Clapton Group Practice.

NHS Property services carried out annual fire risk assessments and we saw the latest report dated June 2014 that included actions required to maintain fire safety. Records showed that there were regular fire alarm tests. However, there had been no fire evacuation drills since 2012. Staff received appropriate fire safety instruction during induction but periodic update training had not been provided for the majority of staff. The lack of fire drills and need for update training were both identified in the latest fire risk assessment.

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 were told that new guidelines and alerts were disseminated by email and discussed at weekly clinical practice meetings, including the implications for the practice's performance and the action required for individual patients. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The GPs we spoke with told us they had special interests in a number of clinical areas including child health; dermatology; diabetes; and reproductive health. 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 continually review and discuss new best practice guidelines to support the effective assessment of patients' needs. To facilitate this, the practice held monthly educational meetings where clinical knowledge was shared. A GP from the practice also attended local NHS acute trust Friday education sessions in person or via webinar. Learning was cascaded to clinical colleagues via email and followed up through discussion at the practice's internal meetings. In addition the practice held regular mentoring sessions where GPs shared clinical practice and learning and provided mutual support.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with 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, there were annual care plans in place for patients with diabetes which included priorities and goals and action plans; information on prescribed medication; and results of diabetes tests including, blood glucose levels, blood pressure, cholesterol, weight and diet, tests on kidneys, eyes and feet. These results and what they meant were discussed with the patient at their next appointment.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. The practice kept registers of patients with learning disabilities and mental health problems to enable their care and treatment needs to be kept under review.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice provided a summary of its programme of 11 audits completed in the last twelve months. These included two completed audit cycles where the practice was able to demonstrate improvement since the initial audit. For example, we reviewed an audit of prescribing of anti-coagulant medicine. The first audit recorded the practice's performance achieved against a standard of 100% in documenting in medical records a range of information on patients requiring a repeat anticoagulant prescription. In the first audit the practice met the standard in four of the ten measures. In the second audit conducted five months later, performance against the standard was compared with the first audit to assess improvement. The data showed the practice now met the standard for six of the ten measures, performance had improved for three of the measures by between 3% and 28% and had fallen by 7% for one of the measures. The reflection of learning and action from the second audit included actions to further improve recording and learning around understanding the rationale behind data entry and coding, ensuring all coding was completed and clear information was entered.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 94.1% of the total QOF target in 2014, which was above the national average of 92.3%. This included the achievement of 100% for several of the QOF clinical targets, scoring above both the CCG and national average. For example:

- asthma related indicators, 1.3% above the CCG and 2.8% above the national average;
- cancer related indicators, 2.7% above the CCG and 4.5% above the national average;

Are services effective?

(for example, treatment is effective)

- COPD related indicators, 2.9% above the CCG and 4.8% above the national average;
- dementia related indicators, 5.5% above the CCG and 6.6% above the national average;
- depression related indicators, 7.7% above the CCG and 13.7% above the national average; and
- mental health related indicators, 6.6% above the CCG and 9.6% above the national average.

There were, however, some areas where QOF achievement was below the CCG and national average, for example;

- diabetes related indicators, 4% below the CCG and 0.1% below the national average;
- heart failure related indicators, 16% below the CCG and 15.7% below the national average;
- hypertension related indicators, 10% below the CCG and 2.6% below the national average.

The practice attributed some of the lower score to the lack of stability in nursing staff over the last year but anticipated improvements this year with more settled staffing now in place.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines, including a repeat prescribing policy. Prescriptions for patients taking regular medicines were accompanied by a computerised list of their medicines. Repeat prescriptions could be ordered on-line, by fax, post, or in person at the practice. Patients were asked to **allow at least 24 hours for repeat prescriptions to be processed before collection.**

Patients with repeat prescriptions were asked to see a doctor or nurse for a medication review six monthly or in some cases annually (for example chronic stable conditions) intervals to decide whether they should continue their medication. There was an alert on the practice's computer to identify when a review was due.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups including patients with learning disabilities and mental health problems. Structured annual reviews were also undertaken for patients with long term conditions, including diabetes, COPD, and heart failure. Under a local long term conditions contract the practice carried out monthly monitoring of clinical prevalence (the number of cases of a disease that are present in a particular population at a given time) and was active in case finding (identifying diagnosed conditions) in this area.

The practice participated in local benchmarking run by the CCG through local and direct enhanced schemes (LES and DES). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. These included LES for frail home visiting and mental health and DES for avoiding unplanned admissions, learning disabilities and dementia.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one having an additional diploma in child health, one in dermatology and diabetes, one in reproductive medicine, one in tropical medicine, one in medical education and four with diplomas in obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

There were arrangements in place for staff to receive mandatory training and additional learning and development. We were provided with pre-inspection information about training completed by staff including child protection, medical emergencies and health and safety. However, there were some gaps in evidence of training staff had received. For example, records indicated the majority had not received fire safety update training since induction, some had not been trained in infection control and the majority had not received training in safeguarding of vulnerable adults.

There was an appraisal system for nursing and non-clinical staff which identified learning and development needs. We saw on staff records that appraisal reports had been completed and staff we spoke with confirmed they had received an appraisal. This included the opportunity to discuss and agree their personal learning and development needs. Staff told us they found the appraisal process helpful and felt the practice was good at supporting training and allowing time to attend courses when needed.

Are services effective?

(for example, treatment is effective)

The practice manager told us that the majority of appraisals had been completed for the current reporting year but two were still to be carried out by the end of the year and arrangements were in hand for this.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, in administration of vaccines, asthma management and medical emergencies.

Administrative staff did not receive formal supervision but said they could speak to their manager for advice whenever they needed to and there were regular opportunities to discuss work matters at monthly practice meetings. We saw from a sample of minutes of these meetings that issues such as staff rotas and the appointment system had been reviewed.

The practice had policies and procedures for managing poor performance but we did not see any evidence that there had been a need to activate these recently.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and usually actioned by a GP on the day they were received. Urgent cases were dealt with by the duty GP. The practice manager and GP partners maintained an overview of all cases and the practice manager reviewed them daily and redistributed them to ensure action was not held up due to doctors' absences. Discharge summaries and letters from outpatients were usually seen and actioned within 24-48 hours of receipt.

Emergency hospital admission rates for the practice were at 19.5% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was

working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems (including dementia, people from vulnerable groups including elderly and frail patients, those with end of life care needs and children and pregnant women on the at risk register. These meetings were attended by district nurses, health visitors, midwives, social workers, palliative care nurses and the community matron. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. We saw examples of such plans for patients with dementia, musculoskeletal problems, and learning disabilities.

The practice attended quarterly 'One Hackney Quadrant' meetings. One Hackney was a new way of working across health and social care based at GP practice level. It supported priority groups of patients, focusing mainly on over 75s with complex needs who needed a special type of rapid response when their condition deteriorated to enable them to remain supported in the community, including people at the end of life. It also provided support to other adults with complex needs. At the quarterly meetings clinical cases were reviewed to identify where gaps were not being addressed and identify learning and improvement.

The practice worked with a range of external professionals to review the needs of specific groups. There were monthly psychiatric liaison clinics with case discussion beforehand and subsequent email advice services. The practice also worked closely with a local psychotherapy service to support patients who were frequent attenders; had medically unexplained symptoms; hard to engage groups and those with personality disorders. In addition the practice had active links with the primary care psychology 'Improving Access to Psychological Therapies' (IAPT) programme which provided self-help courses for patients with common mental health difficulties such as stress, worry and low esteem. The practice had links with local services such as Hackney Law Centre and local food banks to support vulnerable people. The practice also facilitated 'in-house' access to benefits and welfare advice through the Citizen's Advice Bureau (CAB) and Family Action and the

Are services effective?

(for example, treatment is effective)

social prescribing for health scheme (being piloted in Hackney to improve the health of isolated over 50s and people with type 2 diabetes). A CAB advisor was available at the practice on Fridays and from Family Action on Wednesday Mornings.

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 and out-of-hours services. The practice used an electronic system for making referrals, the majority of which were made through the 'Choose and Book' system (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

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

The practice had a consent protocol which was understood and applied by staff. They confirmed they would always seek consent before giving any treatment and would make entries in patient records about consent decisions where appropriate. We saw that consent forms were available for use by clinical staff, for example for minor surgery, birth control implants and the fitting of coils. The protocol covered consent for children under the age of 16 and 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). The consent protocol did not make reference to the Mental Capacity Act 2005 with regard to mental capacity and "best interest" assessments in relation to consent. However, we found clinical staff were aware of the Act with regard to consent and best interest decisions and had received relevant in-house training.

The consent protocol made provision for documenting consent for specific interventions. For example, for any procedure that carried a risk the patient was likely to consider as being substantial. In such cases the clinician carrying out the procedure would make a note in the patient's medical record detailing the discussion about the consent and the risks.

Patients with a learning disability and mental health problems (including those with dementia) were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Patients with a learning disability were provided with an easy read care plan in a pictorial format and we saw a completed example of a patient's plan. This was focused on health promotion and included a record of appointments and details of medication. We were also shown a mental health recovery care plan which had been completed with input from the patient by a primary care mental health liaison nurse.

In February 2015, the practice carried out a CCG commissioned audit of frail home visit care plans used in the practice under a local enhanced scheme (LES). They found the overall quality of care plans was very good, although there were some gaps in the section for anticipatory care. They concluded the care plan was a useful tool but there was not enough focus on emergency planning. These findings were to be fed back through a local GP consortia meeting with suggestions for improvements in care plan design for 2015/16.

Health promotion and prevention

There was a good range of information available to patients in the waiting area which included leaflets which could be taken away from the practice. There was also relevant health promotion information in the practice leaflet and on the practice website. The website included links to the NHS Choices Website, and the most popular health subjects, including sections on family health, long term conditions and minor illnesses.

It was practice policy to offer a health check to all new patients registering with the practice. Risks were identified through the completion of a patient questionnaire. GPs were informed of all health concerns detected and these

Are services effective?

(for example, treatment is effective)

were followed up in a timely way. The practice piloted the near patient testing (an investigation taken at the time of the consultation with instant availability of results to make immediate and informed decisions about **patient** care) of HIV and Tuberculosis (TB) screening for migrant patients registering with the practice. The practice now offered all new patients a new patient HIV test at registration. The practice also encouraged testing other chronic infectious diseases (e.g. Hepatitis C or TB). If patients hadn't already been screened they were encouraged to discuss this in a routine appointment.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. This included a free cardiovascular and diabetes risk assessment and advice on how to reduce the risk. Practice data showed that 114 patients (8.7% in this age group) took up the offer of the health check. If any concerns were identified a follow appointment was arranged to carry out further investigations. Where appropriate patients were referred to the local Healthwise exercise referral scheme, which provided supervised exercise sessions for people with a range of conditions including those with or at risk of coronary heart disease, diabetes, mild to moderate depression and obesity. All patients aged over 75 were offered an annual health check. Patients were asked to make an appointment with the practice nurses. If they were unable to attend the surgery the nurses could visit them at home.

There were also mechanisms in place to support health and wellbeing of particular patient groups in line with their needs. The practice identified the smoking status of patients over the age of 16 and facilitated access to a local smoking cessation service for advice on quitting smoking. The practice sent patients text messages to promote the service. Diabetic patients requiring dietary advice were referred to the monthly diabetic dietician clinic. One of the healthcare assistants was trained in weight management and provided advice to patients with weight problems, including those who were obese. There was a poster in reception encouraging patients to join local walking groups. The practice was represented at monthly multidisciplinary meetings at a local NHS acute trust which considered high risk pregnancies including related obesity, and cases were reviewed with a dietician, consultant and psychologist.

The practice provided a contraception, family planning and sexual health service including fitting caps, coils and implants, giving emergency contraception and providing long acting reversible contraception. The practice promoted pre-natal planning and had recently contacted all diabetic women of child bearing age to remind them of the importance of planning well in advance. The practice offered screening for sexually transmitted diseases (STDs) which was carried out during appointments. The practice advertised and referred patients to City and Hackney Young People's Services (**CHYPS**) Plus (a sexual and mental health service for young people). The practice also promoted the local First Steps psychology service, a counselling service for children, young people and their families who have mild to moderate mental health problems; and the Child and adolescent mental health services (**CAMHS**), for children aged 0-18 and their families who are experiencing mental health problems.

The practice encouraged all women to attend for regular cervical smear testing. They were invited every three years between the ages of 25-49 and every five years from the ages of 50-64. The practice's performance for the cervical screening programme was 81%, which was close to the national average of 82%. Reminders for patients who did not attend for their cervical screening test were made by telephone text and letter and opportunistically during appointments. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes, including bowel cancer and chlamydia screening. Eighty of 342 eligible patients (23%) had attended bowel screening and 34 of 561 (6%) for chlamydia screening.

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:

- Flu vaccination rates for the over 65s were 62%, and at risk groups 57%. These compared to national averages of 73% and 52% respectively.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 90% to 97% and five year olds from 80% to 95%. These were above CCG averages of 67% to 92% for under twos and broadly comparable for five year olds at 77% to 95%.

Are services effective?

(for example, treatment is effective)

The practice routinely updated its computer records with immunisation information from other services and actively chased patients who did not respond to invitations attend for immunisations.

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 2014/15 and a survey of 220 patients undertaken by 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).

The evidence from all these sources showed patients were broadly satisfied with how they were treated and that this was with compassion, dignity and respect. For example, for satisfaction on consultations with doctors in the national patient survey:

- 82% said the GP was good at listening to them compared to the CCG average of 86% and national average of 87%;
- 73% said the GP gave them enough time compared to the CCG average of 84% and national average of 85%; and
- 82% said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and national average of 92%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received fourteen completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good or excellent service and staff were polite, efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. One commented that sometimes there were no nurses and another was unhappy about repeat prescriptions. We also spoke with 11 patients on the day of our inspection, including three members of the PPG. The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some comments were less positive, including lack of time with the GP, and the need for some GPs "to improve their bedside manner."

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 follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us they would take patients to a private area if necessary to maintain confidentiality. In response to the 2013/14 PPG satisfaction survey a third of respondents said other patients could over-hear conversations with receptionists and they were not happy with that. In response the practice discussed with reception staff how this could be minimised and started using another reception desk to reduce congestion at the main desk. The practice also approached the landlord of the premises, NHS property services, with a view redesigning the access area to provide more space and was awaiting a response.

The practice had a zero tolerance policy for abuse regarding any patient who is physically or verbally abusive or threatening towards staff or other patients. The policy was on display in the reception area and was stated on the practice website and in the practice leaflet made available to patients.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed a mixed response to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 66% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 82%; and
- 69% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 75%.

The responses to questions regarding nurses were less positive: For example:

- 49% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 72% and national average of 77%; and

Are services caring?

- 45% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 63% and national average of 66%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. The majority also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. However, there were one or two negative comments in these respects. Patient feedback on the comment cards we received was also mostly positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients gave mixed views about the emotional support provided by the practice in this area. For example:

- 66% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 81%.
- 51% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 72% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were mostly positive. For example, the majority of these highlighted that staff were supportive when they needed help. Three patients, however, felt the care and concern they received had been lacking.

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. 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.

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. Patients we spoke with who had been bereaved confirmed they had received this type of support and said they had found it helpful.

The practice promoted and facilitated patient access to 'the big white wall', an on-line emotional health support forum for people with mental health problems.

The practice looked to identify patients that are carers and promote support services to them. Those identified were coded on the practice computer system and referred to the local carers' centre for advice and support. The practice was the second highest referrer to the centre within the CCG area.

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 patients' healthcare needs and had systems in place to maintain the level of service provided. Patients we spoke with felt the practice met their healthcare needs, and in most respects they were happy with the care provided.

The practice engaged regularly with the local Clinical Commissioning Group (CCG) and other practices at local consortia meetings to discuss local needs and service improvements that needed to be prioritised. For example the practice was collaborating with other practices in comparing referrals and A&E attendance. The practice was represented at board level at CCG and the local GP Confederation. The lead partner was the CCG chair and the practice had lead roles at 'One Hackney Quadrant' and GP consortia meetings. GPs within the practice also represented the practice at CCG learning disability, dermatology and the patient participation sub-committee meetings.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included the employment of a new receptionist to help answer phone calls and reduce queues in reception; on-line appointment access to take pressure off the telephones; improvements to provide patient confidentiality at the front desk, advertising that appointments were 10 minutes in length; a review of the comments form for patients to put in the comments box and making it available at all times in the waiting room; and asking patients to join the PPG at registration at new patient health checks.

The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments, but acknowledged this was a challenge when set against the need to provide urgent appointments. In the national patient survey 2013/14 the practice scored 34% for patients with a preferred GP who usually get to see or speak to that GP. This was 16% below the CCG average. The practice had one male GP, so the choice of a GP for male patients was limited and the practice recognised this as one of its challenges. In the practice's PPG survey, 11% of respondents said they never

or almost never saw their preferred GP and 43% said they saw their preferred GP some of the time. To improve matters in this respect the practice updated the availability of GPs in the practice leaflet and displayed posters around the practice with any changes in working patterns or staffing in the practice. This information was available about all staff on the practice website.

Older patients had access to a bypass number for the practice so they could readily access a duty doctor for services such as a rapid response provider, ambulance service, local acute hospital consultants, to avoid unnecessary admissions and facilitate hospital discharges. Home visits were available for older patients and patients with long term or chronic conditions. Under a local enhanced scheme for frail home visiting the practice made proactive visits and expected to achieve about four visits per 48 vulnerable housebound patients in 2014/15. The practice liaised with other services to enable people with long term conditions to remain in their homes, including first response duty teams, local Acute COPD Early Response Services (ACERS), heart failure nurses and community matrons.

The practice ran antenatal and post natal care clinics including recall for six and 16 week postnatal checks. There was a weekly 'well baby' clinic for these checks and to keep immunisations up to date. Patients could see a health visitor and/or doctor and nurse. Family planning was also provided in normal surgery times.

The practice provided a range of services for patients with chronic health problems. For diabetes they invited patients for a detailed yearly check-up with an initial appointment with a healthcare assistant. There were practice based clinics run by a diabetic specialist (twice weekly), a diabetic dietician (monthly), and heart failure nurses (monthly). Patients who had asthma, heart disease, high blood pressure, chronic lung disease, epilepsy, thyroid disease, a long-term mental health problem or have had a stroke were asked to make an appointment at least once a year for a check-up.

The practice participated in several enhanced services schemes including those for: patients with learning disabilities; child immunisations; influenza and pneumococcal immunisations; reducing avoidable

Are services responsive to people's needs?

(for example, to feedback?)

unplanned admissions; facilitating timely diagnosis and support for people with dementia; extended hours access; minor surgery; remote care monitoring; and risk profiling and case management

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointments were being introduced for patients with two or more long term conditions.

The practice staff had ready access to a telephone advocacy service and reception staff arranged for advocates to attend for longer appointments when appropriate. There was access to telephone translation services and a staff spoke other languages such as Hindi, Spanish and Turkish.

The practice had an equal opportunities policy. Staff were made aware of the policy as part of the induction process and staff we spoke with understood patients' equality and diversity needs covering a diverse population of patients. However, they had not received specific equality and diversity training.

The premises and services had been adapted to meet the needs of patient with disabilities. The surgery has suitable access for wheelchair users and people with other mobility difficulties. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice recognised that disabled access could be improved. Feedback from a previous PPG survey showed that disabled patients found it difficult to access the services at the practice due to lack of facilities. We were told that regional NHS funding had previously been identified to improve access and make other improvements to the building but this was now uncertain.

The practice followed "Once for London" Pan-London principles of registration and did not request documentation so as not to disadvantage any patients. The practice had long historical links with the local traveller community and was aware of their needs as a community and their often complex social and family circumstances. Under a national learning disabilities enhanced service scheme, the practice had sent all patients the Royal College of General Practitioners (RGGP) easy read information and

followed up non responders by telephone. The practice registered patients at a supported living scheme for people with cognitive impairment secondary to chronic alcoholism.

Access to the service

The practice was open from 8.00am to 8.00pm on Monday; 7.00am to 6.30pm on Tuesday; and 8.00am to 6.30pm on Wednesday to Friday. Appointments were available from 8.30am to 11.30am, 3.00pm to 6.00pm and 6.30pm to 8.00pm Monday; 7.00am to 8.00am, 8.30am to 11.30am and 3.00pm to 6.00pm on Tuesday; and 8.30am to 11.30am and 3.00pm to 6.00pm on Wednesday to Friday. If patients provided their mobile number, the practice would send them a text message to remind them of their appointment or for health promotion campaigns.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice offered appointments 'on the day' and 'pre-bookable' appointments 48 hours and one week in advance for patients who needed to arrange their diary in advance. The practice aimed to have appointments for four weeks on the system at any one time. If they were unable to offer patients an appointment and they needed to see a doctor urgently, their details were taken and passed to the 'duty doctor' who would call them back. Doctors and nurses were also available to provide telephone advice and would normally return telephone calls at the end of their surgeries.

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. They were advised they would be put through to the 'out of hours' service who would take details of the problem and pass these to the doctor, who would phone them back as soon as possible.

If patients required a home visit, they were to call reception **before 11:30am. Home visits were available to patients that were housebound or were too ill to visit the practice.** Patients were advised that a GP would only

Are services responsive to people's needs?

(for example, to feedback?)

visit them home if they thought the patient's medical condition required it and would also decide how urgently a visit was needed. Patients could also be visited at home by a community nurse if they were referred by their GP. They would also be visited at home by a health visitor if they had recently had a baby or if they were newly registered with a GP and had a child under five years.

Several patients we spoke with and two from whom we received comments cards raised issues about the appointments system. Some said it was hard to get through to the practice on the phone to make an appointment and experienced long delays with this. Comments received from patients showed that those in urgent need of treatment were usually able to make appointments on the same day of contacting the practice. However, others said there were delays in getting non-urgent appointments. Some patients were unhappy with waiting times when they attended for appointments and said they were not informed of delays when they arrived.

Data from the national GP patient survey showed 84% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. Eighty three percent said their last appointment was convenient but only 49% described their experience of making an appointment as good.

Forty four percent found it easy to get through to the surgery by phone (30% below the CCG average).

Thirty eight percent of respondents said they usually wait up to 15 minutes after their appointment time to be seen, which was 23% below than the CCG average. Sixty nine percent were satisfied with the surgery's opening hours but only 32% said they don't normally have to wait too long to be seen.

The practice acknowledged there was continuing dissatisfaction with the appointments system despite significant changes made to improve the system, including the introduction of a duty doctor, and the employment of an additional receptionist and reception manager. Further action to address this included the planned introduction of a new telephone system with a queuing facility and wider communication to patients about the appointments system.

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice manager was the complaints manager and the lead GP partner led on clinical complaints. The complaints procedure, dated August 2014, explained how patients could pursue matters further with other organisations if they were dissatisfied with the handling of their complaint, including the Parliamentary and Health Service Ombudsman (PHSO). However, the procedure still referred to the Primary Care Trust (PCT), which was no longer in existence. This had been updated, though on the website, which referred to NHS England as an alternative avenue through which to pursue matters further.

We saw that information was available to help patients understand the complaints system. There was a complaints leaflet in both English and Turkish available in reception, although this was not readily accessible to patients. There was also information about making complaints in the practice leaflet and on the practice website. Patients we spoke with were not all aware of the complaints procedure but the majority said they had not needed to make a complaint about the practice.

We looked at six complaints received in the last year which included a summary of the complaint, action taken, the response and lessons learned. We saw that these were dealt with in a timely manner. The letter of response offered an appropriate explanation and apology.

Staff we spoke with were generally aware that patients could complain about the service and were aware of the complaints procedure document. We were told that learning from complaints was discussed within the practice and the practice's analysis of complaints recorded a number of instances where discussions had taken place, for example in relation to a complaint about sharing patient information with other agencies where staff were reminded when communicating with other services to ensure that only appropriate patient information was included. We also saw evidence of discussion of complaints and lessons learned in the minutes of meetings we reviewed and complaints were a regular item on the agenda.

Listening and learning from concerns and complaints

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 ethos which involved putting patients first and was committed to providing them with the best possible service. Underpinning this, the practice followed standards set by external health agencies including the local CCG and NHS England. The practice's statement of purpose set out the aim and objectives of the service. The overall aim of the practice was to work in partnership with the local community to providing high quality, safe, effective, evidence based primary care services to the practice population, based on a patient centred approach, respecting and supporting the diversity that is present within our local community. Not all staff we spoke with were aware of the statement of purpose and the practice aims were not on display for patients. However, all staff were able to articulate the essence of the practice ethos and it was clear that patients were at the heart of the service they provided.

Governance arrangements

The practice had a comprehensive range of policies and procedures in place to govern activity and these were available to staff via the computer system within the practice. There was a staff handbook containing appropriate human resource policies. Separate clinical practice policies and procedures including policies on consent, infection control and chaperoning, were also accessible to all staff. The policies were subject to regular review and updating and all the policies we looked at had been reviewed in the last year.

There was a clear leadership structure with named members of staff in lead roles. For example, there were named GP leads for safeguarding, infection control, medicines management, and clinical governance. We spoke with eight 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 used the Quality and Outcomes Framework (QOF) to measure its performance. QOF data showed the practice performed above other practices in the local CCG

area about two thirds of the indicators in the year ending April 2014 and in many of them scored 100%. QOF data was regularly discussed at clinical team meetings and action planning put in place to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, repeat audits of patients prescribed anticoagulants and patients on high risk drugs, and an audit of surgical referrals. In the audit of high risk medicines the first audit recorded the practice's performance achieved against seven criteria. 100% was achieved in four of the seven. In the second audit conducted six months later, there was a significant improvement in performance against the three other criteria by between 14% and 83%. The reflection of learning and action from the second audit included actions to ensure medicines were not routinely used unless blood monitoring was up to date; ensuring the mandatory use of high risk drug monitoring templates; ensuring overdue medication reviews were not overlooked; and the review of potential side effects and risks of high risk drugs.

The practice had arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The practice regularly monitored and reviewed risks to individual patients, using specific risk assessment and management tools where appropriate, and updated patient care plans accordingly. A combined health and safety and fire risk assessment had been completed in January 2015 and the action plan implemented.

The practice held weekly governance meetings which covered business issues, patient case discussions and multi-disciplinary reviews. We looked at minutes from a sample of these meetings and found that performance, quality and risks had been discussed.

The practice held monthly educational meetings where clinical knowledge was shared. In addition the practice held regular mentoring sessions where GPs shared clinical practice and learning and provided mutual support.

Leadership, openness and transparency

We saw from minutes that staff meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team

Are services well-led?

Good 

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

meetings. Staff felt that the practice worked well as a team and provided mutual support. Staff felt that communication within the practice was generally good, although one member of staff told us some changes, for example in clinical templates, could have been communicated more clearly. Another suggested that a greater presence at clinical meetings of GP partners from both the practice and the Lower Clapton Group Practice would facilitate staff support and foster wider discussion of clinical issues, such as QOF performance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, induction policy, and disciplinary procedures, which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on work standards, sickness, on equality, harassment and health and safety at work. Staff we spoke with knew where to find these policies if required.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The PPG had an email forum and aimed to meet bi-monthly. The group included representatives from various population groups including representatives from British, African, Caribbean and Turkish backgrounds. One of the practice's salaried GPs was the CCG lead for patient participation and involvement and encouraged PPG engagement within the local GP consortia and CCG. The practice's PPG carried out annual surveys and we were shown the analysis of the last patient survey, conducted in 2013/14 which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

We spoke with three members of the PPG. While they were generally positive about the role the PPG played and felt engaged with the practice, they told us there were only five active members currently. They felt that more could be done to advertise the activities of the group, as there were no notices in the surgery to attract volunteers. They felt also the 6.30pm meeting time for the PPG meetings was

not convenient for elderly patients who may wish to be involved. We noted that on the practice's website patients were invited to join the group by completing an on line form or by printing a copy of the form and bringing it completed to the practice. Patients could also sign up for email communications from the PPG.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy but not all staff we spoke with were aware of the policy. However, they knew who to go to if they wished to report any concerns.

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 staff records and saw that they received regular appraisals and learning and development needs were linked to the appraisal process through individual personal development plans.

The practice had completed reviews of significant events and other incidents which included lessons learned. For example, following medical complications that arose in the course of a patient's pain management regime, the practice highlighted the importance of establishing a firm pain management plan that all GPs in the practice adhered to in treating the patient. It was also agreed that it was essential that such cases should be discussed by the whole practice team to ensure the patient's treatment was properly co-ordinated and managed. Staff we spoke with confirmed that the outcomes of significant events were discussed with them.

Staff told us that the practice supported them to maintain and update their knowledge, skills and competence through training. We looked at staff records and saw that staff received appraisals which included a learning and development plan. Staff told us they had undergone an induction process on appointment and we saw evidence of its completion for individual staff members.

The practice occasionally taught medical students and nurses but there were no trainee placements at the practice at the time of our inspection.

Are services well-led?

Good 

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

The practice had completed reviews of significant events and other incidents which included lessons learned. For example, as a result of a document scanning error a patient was not referred for a hospital appointment as intended. As a result of lessons learned reception staff now scanned

immediately any documents brought in by patients or family/carers and these were put for the attention of the duty doctor the same morning/afternoon. We were told that any significant events would be discussed at practice meetings and we saw evidence of this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who use services were not fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out or recorded prior to a staff member taking up post. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.