The Allum Medical Centre

Quality Report

The Allum Medical Centre
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Date of inspection visit: 6 November 2014
Date of publication: 21/05/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected The Allum Medical Centre on 06 November 2014. This was an announced comprehensive inspection. Overall the practice is rated as good

We rated the practice as good for being safe, effective, caring, responsive to people's needs and well-led. We rated the practice as good for the care provided to older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- The practice completed reviews of significant events and other incidents and there was evidence that these were used as learning points for clinical staff;
- Training records showed that staff were up to date regarding mandatory training such as safeguarding children and vulnerable adults. We also noted a good skill mix amongst the doctors. For example, some had undertaken further specialist training in sexual and reproductive medicine;
- Patients spoke positively about how they were treated by staff and we noted that this was consistent with comment cards and patient survey feedback;
- The practice had an active Patient Participation Group (PPG - a patient led forum for sharing patients' views with the practice). Patients spoke positively about how their views were taken on board, highlighting for example the introduction of an online facility to order repeat prescriptions and make appointments; so as to relieve pressure on the practice's phone system.
- The practice had clear leadership. Senior GPs saw the vision of the practice as being to deliver good quality, patient centred care. We spoke with a range of staff including practice manager, reception staff, the medical care practitioner and GPs, who all understood their roles and responsibilities in delivering this vision.

However, there were areas of practice where improvements were needed. Importantly, the provider should:

Summary of findings

- Amend its current cleaning schedule to include individual practice areas such as waiting rooms and treatment rooms;
- Ensure that all non clinical staff undertaking chaperoning duties receive training.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. For example, the medical care practitioner's description of how they would escalate a safeguarding concern was consistent with the practice policy. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients and staff were assessed and well-managed, for instance by carrying out infection prevention and control audits. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. For example, unplanned hospital admission rates for patients with coronary heart disease were below the averages for practices in Waltham Forest and England. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams although not all meetings were minuted. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. We saw evidence that clinical audits were being used to help improve patient outcomes. However, there was no evidence of a systematic programme of audits.

Are services caring?

Good

The practice is rated as good for providing caring services. Patient satisfaction was higher than Waltham Forest CCG practice averages regarding helpfulness of reception staff and patients' involvement in decisions about care. Patients told us they were treated with compassion, dignity and respect. Information to help patients understand the services available was easy to understand. They also told us that they felt involved in decisions about their care and treatment and we noted that this was also a consistent theme of patient comment card feedback. We saw that staff treated patients with kindness and respect, and maintained confidentiality. NHS England 2014 national GP patient survey results highlighted that 83% of patients found receptionists helpful.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with

Summary of findings

Waltham Forest Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Referral arrangements were also in place with voluntary sector organisations enabling specialist support to be provided for local population groups such as expectant mothers and local Asian communities. The practice was well equipped to treat patients and meet their needs. For example, longer appointments were offered for those that needed them and we saw that language interpreting (including British Sign Language) was available. Urgent same day appointments were available but not usually with a named GP. The premises also had good facilities including ramped wheelchair access, baby changing facilities and specially designed waiting room seating which was reserved for patients with impaired mobility.

Information about how to complain was available and easy to understand. We saw evidence that the practice responded quickly to issues raised. However, although there was evidence that complaints were reviewed annually we noted that this did not include an analysis of complaints, to identify any themes or trends. Patient surveys highlighted dissatisfaction with the practice phone system. The practice told us that online appointments and repeat prescription facilities had been added to the website in order to address patients' concerns and to relieve pressure on the phone system. However, at the time of our inspection, it was too early to assess any impact this may have had.

Are services well-led?

Good

The practice is rated as good for providing well led services. There was clear leadership and staff told us they felt supported by management. The practice also had a clear vision and staff explained how their roles and responsibilities contributed to this vision. The practice had a number of policies and procedures to govern its work and the services provided. It held regular governance meetings, including for example to monitor significant events. There were also systems in place to monitor and improve quality. These included clinical meetings, where patient outcomes were reviewed and action plans developed as necessary. There were also systems in place to identify and act on risk (such as infection control audits). The practice proactively sought feedback from its Patient Participation Group (PPG) and members confirmed that the practice acted on their feedback. There was a strong focus on continuous learning and improvement at all levels of the organisation.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance (including the Mental Capacity Act 2005). Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people, such as diabetes. The practice was responsive to the needs of older people offering, for example, home visits, rapid access appointments and extended appointment slots. When we spoke with older patients they were positive about how they were treated by staff and we noted that they were well represented on the Patient Participation Group. Patients aged over 75 had their own named GP and were offered annual health checks.

The practice performed better than the Waltham Forest CCG average for dementia diagnosis rates. Records showed that the practice routinely reviewed the care of patients on its end of life care register, working closely with specialist end of life care nurses.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. Patients had a named GP and practice nurses regularly reviewed patients on long term condition registers to check that their health and medication needs were being met. Patients with long term conditions told us that clinicians provided sufficient information to enable them to make informed decisions about their care and treatment. We noted that unplanned hospital admission rates for patients with diabetes were higher than the practice averages for Waltham Forest but lower for coronary heart disease. We saw evidence of how the practice worked with healthcare professionals such as health visitors, district nurses and end of life nurses to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates at 12 and 24 months were better than the average for Waltham Forest CCG practices. Appointments were available outside of school hours and the premises were suitable for children and babies, for example, baby changing facilities were available. Health visitors were based in the same building and we saw evidence of how this facilitated joint working

with practice staff. The practice also worked closely with midwifes and school nurses. Practice staff were aware of local safeguarding contacts and knew how to escalate concerns. Practice nurses specialised in women's health and contraception.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included telephone consultations, early morning appointments, a GP call back service, online appointment booking and repeat prescriptions requests. However, some patients fed back that it was difficult to get through to the practice by telephone. The practice offered a full range of health promotion and screening that reflected the needs of this age group. Health promotion material was available throughout the practice, including via a TV in the patient waiting area. The practice's website contained links to NHS Choices healthy living advice webpages.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances. Patients with a learning disability were offered annual health checks and longer appointments. We also noted that "easy read" pictorial leaflets were available, outlining various treatments and conditions. Some patients with a learning disability lived at local care homes. When we asked staff how they ensured that these patients received equitable care, they stressed the importance of treating each patient as an individual.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, recording safeguarding concerns and how to contact relevant agencies both during and out of normal working hours.

The practice offered interpreting services in a range of languages including British Sign Language (BSL).

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice kept a register of patients experiencing poor mental health. GPs

Summary of findings

stressed the importance of reviewing patients' physical health as well as their mental health and we noted, for example, that the practice performed better than the Waltham Forest CCG and England averages for cholesterol checks in the last 12 months for patients experiencing poor mental health.

The practice offered flexible appointments such as evening appointments when the practice was less busy; as we were told that this was preferred by many patients experiencing poor mental health. The practice also had a range of systems in place to support patients presenting with acutely poor mental health. For example, it routinely referred patients experiencing poor mental health to local voluntary sector organisations providing specialist support.

Summary of findings

What people who use the service say

During our inspection, we spoke with 21 patients. Overall, they were happy with both the care and treatment they received and with the practice environment. Some patients were also members of the practice's Patient Participation Group (PPG) and gave examples of how the practice had listened and acted upon patients' concerns, such as making suggested changes to the patient waiting area.

We also reviewed 14 patient comments cards. These had been completed by patients in the two week period before our inspection and enabled patients to record their views on the practice. Feedback was uniformly positive, with key themes being that staff were respectful, that they listened and were compassionate.

We used existing patient feedback to guide our discussions with patients. For example, the NHS England national patient survey 2014 highlighted that 54% of respondents found it easy to get through to the practice by telephone. This compared with the Waltham Forest CCG average of 63%. We were told that following feedback from the PPG, the practice had introduced on line facilities for patients to make appointments and request repeat prescriptions to relieve pressure on the telephone system. However, at the time of our inspection, it was too early to assess impact.

Patients told us that they felt involved in decisions about their care and treatment and that their questions were answered. This was consistent with national patient survey data, which highlighted that 73% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. This was better than the Waltham Forest CCG practice average of 68%.

In January 2014, the practice conducted its own patient survey. We noted that from the 101 patient responses, 95% fed back that reception staff were helpful and 64% fed back that they were able to see a GP on the same day. However, 43% of respondents found it difficult to get through to the practice by telephone. Overall, 92% of respondents were happy with their consultation.

Areas for improvement

Action the service SHOULD take to improve

- Amend its current cleaning schedule to include individual practice areas such as waiting rooms and treatment rooms;
- Ensure that all non clinical staff undertaking chaperoning duties receive training.

The Allum Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and an expert by experience. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to The Allum Medical Centre

The Allum Medical Centre is located in Waltham Forest, an outer east London borough. Public Health England's Waltham Forest 2014 Health Profile states that the health of people in Waltham Forest is varied compared with the England average. Life expectancy is similar to the England average for the borough as a whole. In the most deprived areas of the borough, life expectancy for men is 6.0 years lower and for women 6.6 years lower than in the least deprived areas.

Deprivation is higher than average and about 28.3% (16,000) children live in poverty. By the time children reach age ten 22.9% (603) of children in Waltham Forest are classified as obese, worse than the average for England. Levels of GCSE attainment are worse than the England average. Levels of breastfeeding and smoking at time of delivery are better than the England average. In 2012, 17.1% of adults were classified as obese, better than the average for England. Estimated levels of adult smoking are worse than the England average as are rates of sexually transmitted infections and TB.

In Waltham Forest, strategic improvements in health and wellbeing are led by the borough's Health & Wellbeing Board; comprised of Waltham Forest Council, Waltham Forest CCG, Waltham Forest Healthwatch and other health stakeholders. Priorities include helping adults and children achieve a healthy weight, reducing alcohol related harm and hospital admissions, and tackling poor health associated with child poverty.

The Allum Medical Centre has a patient list of approximately 15,800 (the largest in Waltham Forest). Twenty one percent of patients are aged under 18 and 7.5% are 65 or older. Forty eight percent of patients have a long-standing health condition, whilst 22% have carer responsibilities.

The practice is registered to provide the following regulated activities which we inspected: treatment of disease, disorder or injury, diagnostic and screening procedures, surgical procedures, family planning, maternity and midwifery services.

The services provided by the practice include child health care, ante and post natal care, immunisations, sexual health and contraception advice, management of long term conditions and smoking cessation clinics. The staff team comprises four senior GPs (one female, three male), one female salaried GP, two female practice nurses, one female medical care practitioner, practice manager and administrative/reception staff. The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities. The practice has opted out of providing out-of-hours services to their own patients.

The CQC intelligent monitoring placed the practice in band four. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP

practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 06 November 2014. During our visit we spoke with a range of staff, including GPs, the medical care practitioner, the practice manager and reception staff. We also spoke with patients, including members of the Patient Participation Group (PPG). We observed how people were being cared for and talked with carers and/or family members. We also reviewed comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. These included reviewing reported incidents and comments or complaints received from patients. Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, the medical care practitioner's description of how they would escalate a safeguarding concern was consistent with the practice policy. We also noted that there were effective arrangements in place to report safety incidents which were in line with national and statutory guidance.

The practice had a safety alert procedure to ensure that national drugs safety alerts received were shared with all staff at the practice. Staff knew their roles and responsibility under this procedure. For example, the practice manager outlined their role in acting on alerts received from Waltham Forest Clinical Commissioning Group (CCG), ensuring that printed copies of the alerts were placed on file. We noted that clinicians also received these alerts from the CCG.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We looked at eleven events recorded since April 2013. They included a record of the concern, together with any action taken to minimise the chance of a recurrence and lessons learnt. Significant events were discussed at weekly clinical meetings and more detailed analyses took place at bi-monthly meetings. A senior GP was the significant events lead and had responsibility for sharing learning amongst staff. Their role also included helping staff to understand and fulfil their responsibilities to raise concerns and report incidents or near misses.

Records showed how the practice used significant events reviews to improve the service. For example, following a medications error relating to two patients with the same name, changes had been made to how patient data was recorded.

Reliable safety systems and processes including safeguarding

There were systems in place which ensured patients were safeguarded from the risk of abuse. A senior GP was the designated safeguarding lead and the practice had ensured all staff were trained in protecting vulnerable adults and children from abuse to the appropriate level. For example, GPs and nurse practitioners were Level 3 trained in child protection and non- clinical staff had attended basic children and vulnerable adults safeguarding training. Staff were able to recognise signs of abuse, including in older patients, and knew how and to whom they would report or escalate a concern. The practice had policies relating to child protection and adults who were at risk. The policies included details of who to contact at the local authority and CCG and staff were aware of the contact details. GPs contributed to child protection meetings either by submitting reports or attending in person. The practice nursing team was in regular contact with the borough's health visitors and were able to raise any safeguarding concerns they had.

The practice had a chaperone policy and we noted that non- clinical staff who undertook chaperone duties had undergone appropriate Disclosure and Barring Service (DBS) checks. However, not all staff had received chaperone training.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information advising of any relevant issues when patients arrived for their appointments. The included patients experiencing poor mental health, young mothers who were deemed at possible risk and patients living with dementia.

Medicines Management

We checked medicines stored in the medicines refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. The policy included instructions on what action to take in the event of a power failure. We looked at daily temperature records of the medicines refrigerators and noted that they were within the required parameters. The practice did not hold Controlled Drugs on the premises. Medicines were within their expiry date.

We saw evidence that the practice undertook medications reviews triggered by national drugs safety alerts or NICE guidance. For example, we saw an ongoing audit regarding the prescribing of two medicines, which had been triggered by a drugs safety alert. The audit identified patients at risk and the practice was in the process of reviewing and changing the medication of the patients concerned.

Good

Are services safe?

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, being kept securely at all times and tracked through the practice once filled in.

We noted that five of the eleven significant events recorded since April 2013 related to medicines management. These included a medicines refrigerator door coming open thus activating an alarm and a medications prescribing error. Records noted that none of the incidents had resulted in significant harm to patients. We noted that for each of the significant events, the practice had identified learning outcomes to minimise the chance of recurrence and amended its systems as required. For example, following a medications prescribing error, we noted that more stringent supervision had been introduced regarding medicines management.

Cleanliness & Infection Control

Patients were treated in a clean, hygienic environment. All communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor. Patients spoke positively about the environment.

We noted that the treatment room where minor surgery took place was subject to an individual cleaning schedule, covering elements such as the couch, lamp and window ledges. However, although we saw a generic cleaning schedule for the whole premises, we noted that this was not divided into individual areas such as the treatment rooms or waiting areas. The practice told us that they would immediately amend their cleaning schedule to include individual areas.

Treatment rooms had vinyl flooring and we noted that clinical waste awaiting collection was stored securely away from patient areas. 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. Hand gel was also available in waiting room areas.

The practice's medical care practitioner was the Infection Prevention and Control (IPC) lead and responsible for ensuring effective infection control throughout the practice. Records showed that they had recently attended infection control training as part of this role. Personal protective equipment such as gloves and aprons were readily available for staff to use.

The practice had an infection control policy. The policy stated that infection control audits were to take place every six months however we noted that the last audit on file had taken place in January 2014. The audit had led to an action plan which the practice was in the process of implementing (for example replacing shelving with cupboards in its treatment rooms).

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. For example, we noted that the fire alarm had been tested within the past year. We also saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

Staffing & Recruitment

The practice had systems in place to ensure that staffing levels and skills mix were planned, implemented and reviewed to keep people safe at all times. Electronic records showed that actual staffing levels and skill mix were in line with planned staffing requirements.

The practice had recruitment procedures in place that ensured staff were recruited appropriately. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) for all clinical staff and for non- clinical staff who undertook chaperone duties. The majority of staff had been employed by the practice for more than ten years. New staff completed an induction process which included training in infection control and prevention, and health and safety and an overview of staff members' roles.

Good

Are services safe?

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual, bi-annual and monthly checks of the building and equipment, infection control, medicines management and staffing requirements. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. For example, the practice's latest infection control audit identified and took appropriate steps to minimise risk from dust accumulating on treatment room shelves.

We also saw that staff were able to identify and respond to changing risks to patients, including deteriorating health and well-being. For example, the medical care practitioner explained protocols for vulnerable young mothers to be seen by GPs. We also noted that systems were in place to respond to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

There were sufficient systems in place to deal with a medical emergency. The practice had an automated external defibrillator, emergency medicines and oxygen. Regular checks of this equipment were undertaken by an allocated nursing staff member. Clinical staff had received cardiopulmonary resuscitation (CPR) training within the last twelve months. Non clinical staff had received CPR training within the last three years.

Plans were in place to respond to emergencies and major situations. The practice had a business continuity plan which instructed staff of what to do in the event of an emergency. The plan covered areas such as pandemic flu, fire, staff shortage and IT system failure. It contained relevant contact details for staff to refer to, such as support numbers in the event that the practice's clinical software failed. We were told that the plan had been implemented in the last twelve months following a power failure. We noted that staff understood their roles and responsibilities.

Good

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 saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found that GPs and nurses completed thorough assessments of patients' needs in line with NICE guidelines. These were reviewed at clinical performance meetings held every six-to-eight weeks.

For example, records showed that clinicians were reminded to regularly review urine protein levels of patients with chronic kidney disease (CKD) as this could give an early detection of high blood pressure. This was in accordance with NICE guidelines. The practice's performance on review of urine protein levels of patients with CKD was 84% which was better than the averages for Waltham Forest CCG (78%) and England (76%) respectively.

GPs told us that each led in specialist clinical areas such as diabetes, heart disease and asthma. The medical care practitioner supported this specialist work; allowing the practice to focus on specific conditions. We noted that staff were actively involved in a range of information sharing opportunities. These included the medical care practitioner chairing the local practice nurse forum and GPs having policy advisory roles with the national NHS Alliance and Royal College of General Practitioners (RCGP). Staff told us this supported them to continually review and discuss new best practice guidelines and spoke positively about how this helped ensure that care was provided in accordance with latest guidance and best practice. They also spoke positively about an open practice culture where advice and support were readily available.

We saw that patients had comprehensive assessments of their needs. These included consideration of their physical health and wellbeing, their mental health and clinical needs. For example, practice performance on percentage of new depression diagnoses which had had a review not later than the target 35 days after their diagnosis was 73%, compared with the England practice average of 58% and the Waltham Forest average of 50%. We also noted that the practice's performance on diabetic patients who had had a foot examination and risk classification in the last 12 months was better than the Waltham Forest average (respectively 86% and 82%). This is important as patients with diabetes are at high risk of foot complications.

The practice regularly invited specialist clinicians to its weekly clinical meetings. We were further advised that clinical performance meetings took place every six to eight weeks, where actions could be agreed to improve patient outcomes as necessary.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included inputting data, scheduling clinical reviews, managing child protection alerts and medicines management. The practice manager collated information and used it to support the practice's clinical audits.

Two completed clinical audits had taken place in the last twelve months; triggered by research in specialist medical press on effectively reducing usage of insomnia drugs amongst older patients; and also triggered by the patent of an erectile dysfunction drug coming to an end. The audit templates covered objective, sample size, evidence of action taken and the practice was able to demonstrate resulting changes.

Information about patients' care and treatment, and their outcomes, was routinely monitored and information used to improve care. The practice performed better than the national average in a number of Quality and Outcomes Framework (QOF) areas for the year ending April 2014. QOF is a national performance measurement tool relating to GP services. For example, we noted that the practice performed better (5% per 100 patients on register) than the Waltham Forest and England practice averages for unplanned hospital admissions for patients with coronary heart disease (7.7% and 7% respectively). Performance regarding women who had had cervical screening within the last five years was also slightly better than the Waltham Forest CCG average.

The practice attributed its QOF performance to the nursing team's proactive approach to delivering chronic disease management and screening programmes. We also noted

Good

Are services effective?

(for example, treatment is effective)

that QOF performance across a range of clinical areas was discussed at clinical performance meetings with action plans being developed as appropriate to improve performance.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all staff were up to date regarding mandatory training, for example safeguarding. We noted a good skills mix amongst the GPs with two undertaking external GP appraiser duties. GPs were up to date with their yearly continuing professional development requirements and had had their five yearly medical licence revalidation within the last 12 months. There were both female and male GPs. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England

The practice had systems in place to identify and meet the learning needs of staff. Records of team meetings showed that managers were proactive in identifying and monitoring staff training requirements.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Administrative staff were managed by the practice manager and had had annual appraisals within the last twelve months; where performance was reviewed and training needs identified. Staff told us that although formal supervision meetings did not take place, they felt supported in their roles. Practice nurses were appraised by the medical care practitioner and we saw that this appraisal process also identified training needs.

Working with colleagues and other services

The practice had systems in place to help ensure that when care was received from a range of different teams or services it was coordinated. The nursing team worked closely with the local health visitor team, district nurses and midwifery teams, who are based in the same building. We were told that regular discussions between the various professionals took place, although these were not always minuted.

Internal and external speakers were regularly invited to attend clinical meetings and we noted that the practice also worked closely with a range of services including specialist mental health and carer voluntary organisations. We also saw evidence of meetings to discuss the care of patients with long term conditions and/or end of life care needs.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care including test results and information to and from other services such as hospitals. All staff were fully trained on the system and commented positively about the system's safety and ease of use. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff demonstrated knowledge and understanding of consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Systems were in place to support patients to make decisions. Where appropriate this included an assessment of their mental capacity. Clinical staff demonstrated an understanding of Gillick competencies, which help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. There was some evidence that care plans were appropriately reviewed and that they contained details of the patient's preferences for treatment and decisions. However, only 6% of patients on the register had an agreed care plan on file compared with the national average of 9%.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

The practice worked closely with Waltham Forest CCG to share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information

Good

Are services effective?

(for example, treatment is effective)

about the health and social care needs of the local area and is used to help focus health promotion activity. This information was used to help focus health promotion activity.

For example, a range of health promotion activity took place including ante natal clinics, sexual health clinics and smoking cessation. It was practice policy to offer a health check with a practice nurse to all new patients registering with the practice. We noted that the reception area contained patient information on conditions which were prevalent amongst the local community such as diabetes.

The practice also offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Latest available practice performance data for immunisations at 12 and 24 months was above the average for Waltham Forest practices. Dementia diagnoses rates were also better than the national average. We noted that at 75.6%, practice performance on cervical screening within the last five years was slightly better than the Waltham Forest practice average (75.1%) but below the England practice average (76.9%).

However, cervical screening rates for women experiencing poor mental health were worse than the averages for Waltham Forest and England. Seasonal flu vaccination rates for "clinical risk groups" such as patients with a learning disability or diabetes were also worse than the England practice average.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Before our inspection, we looked at NHS England 2014 national GP patient survey results which showed that 83% of patients found receptionists helpful. During our inspection, we observed that reception staff treated patients with dignity and respect. Patients spoke positively about how they were treated by GPs and practice nurses and this was also consistent with comment card feedback.

We noted that the practice offered a chaperone service which was publicised in the reception area. Reception staff undertaking chaperone duties had undergone DBS checks, but had not received training.

The national patient survey fed back that 56% of respondents were satisfied with the level of privacy when speaking at reception. During the inspection, we observed that the reception area was adjacent to the waiting areas. Although the practice had installed barriers to limit access to the reception desk and improve privacy, conversations between the receptionists and patients could be overheard. However, none of the patients we spoke with or comment cards reviewed, identified privacy in reception as an issue.

Care planning and involvement in decisions about care and treatment

The national patient survey showed that 73% of the practice's patients who responded said the last GP they saw or spoke to was good at involving them in decisions about their care. This was better than the Waltham Forest practice average of 68%. During our inspection, patients told us that they felt involved in decisions about their care and treatment and we noted that this was also a consistent theme of patient comment card feedback. However, we noted that the practice's QOF performance was below the national average for the percentage of patients who had a documented comprehensive care plan on file, agreed between individuals, their family and/or carers as appropriate (respectively 61% and 87%).

Staff demonstrated knowledge and understanding regarding obtaining patients' consent to treatment, for example, speaking of the importance of an ongoing assessment of patients' capacity to consent. One GP also told us that the importance of involving a patient in decisions about their care was not negated in circumstances where the patient had a carer.

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

Patient/carer support to cope emotionally with care and treatment

The practice routinely wrote to patients diagnosed with cancer to offer support and help. This was to ensure that patient care was coordinated between the practice and specialists, as required. The practice also provided patients with information about organisations offering specialist support. Records showed that nurses specialising in end of life care regularly attended multi-disciplinary meetings at the practice. This helped to ensure that emotional and caring support were coordinated. Patient discussions and comment card feedback highlighted that staff acted compassionately when patients needed help and support such as during times of bereavement.

Patients were provided with information regarding local and national support groups and organisations offering specialist support, such as those relating to cancer and diabetes. Information was given by way of notices in the waiting room, as well as by information bulletins on the waiting room TV screen. The practice website also provided patients with information on how to access support groups.

The practice routinely signposted patients to organisations providing specialist support such as cancer and diabetes support. Records also showed that end of life care nurses regularly attended multi-disciplinary meetings at the practice to ensure that emotional support and caring support were coordinated.

We noted that 22% of patients had a caring responsibility (above the England average) and asked staff about support offered. We were advised that the practice routinely signposted patients to a local carer support network. We also noted that carer's information was provided in the practice reception and on the practice website.

We also looked at care provided for patients diagnosed with depression and noted that the practice's QOF

Good

Are services caring?

performance was better than the Waltham Forest and England practice averages for patients with a new diagnosis of depression who had had a review not later than the target 35 days after diagnosis.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered a range of appointment options to meet the needs of its patient groups including appointment booking by phone, online or in person. Early morning 7am extended hours were available Monday –Friday in addition to a telephone consultation service. The practice provided a named GP and extended appointment slots for patients aged over 75 years or who had a learning disability. Home visits were available and patients were also able to leave messages with reception requesting that a GP call them back. The practice also provided care and treatment to patients living in local nursing homes.

The practice offered a range of services to meet the needs of its patient groups. These included ante natal clinics, sexual health clinics and smoking cessation advice. The practice's QOF performance was better than the practice average across a number of patient group areas including child immunisations rates at twelve months, twenty four months and five years old; and regarding testing of chronic kidney disease patients within the preceding fifteen months for early detection of high blood pressure (where the practice performance of 84% was better than the Waltham Forest CCG average (76%) and England practice average (79%)).

The practice was able to offer good continuity of care because there had been very low turnover of staff during the last five years Most of the partner GPs had started at the practice as salaried GPs and the majority of non-clinical staff had been with the practice for several years.

Information about the needs of patients was used to inform how services were planned and delivered. The practice had a "virtual" Patient Participation Group (PPG - a patient led forum for sharing patients' views with the practice). The PPG was comprised of over 80 patients who participated by email. Members spoke positively about how the group's views were taken on board. For example, following the January 2014 survey the practice had introduced a system for patients to make appointments and request repeat prescriptions on line, to relieve pressure on the telephone system. We also saw that the group had developed an action plan with time scales to which the practice was working.

Tackling inequity and promoting equality

The practice was wheelchair accessible which also allowed patients with mobility scooters and wheelchairs to access the practice. One of the toilets was wheelchair accessible and also contained baby changing facilities. The waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the consultation rooms. A wheelchair was available in reception for less-mobile patients to use. There was a hearing loop in the reception area for patients with a hearing impairment. The practice made use of an interpreter service which could provide British Sign Language interpreters and we noted that interpreting services were also available in other languages. The practice was arranged over four floors connected by a lift. The practice saw patients with impaired mobility in ground floor treatment rooms.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice offered extended appointments and "easy read" pictorial leaflets for patients with learning disabilities. An area of seating in the waiting area was reserved for older patients and there was also raised seating designed for less mobile patients. When we asked staff how they ensured that patients with a learning disability received equitable care, they stressed the importance of treating each patient as an individual. Records showed that staff had completed equality and diversity training.

Annual health checks were provided for patients who experienced poor mental health. The practice also offered flexible services and appointments including for example, evenings appointments (when the practice was less busy) as this was preferred by many patients.

The practice sent text appointment reminders to all patients who had provided their mobile phone numbers. We were told this was particularly supportive to patients with a hearing impairment or those who were living with dementia. A screen which displayed the name of the next patient to be seen was located in the waiting area. This was responsive to the needs of patients with a hearing impairment.

Access to the service

Appointments were available from 7:00am to 11:30am and 2.30pm to 8pm Monday to Friday. Comprehensive information was available to patients about appointments

Good

Are services responsive to people's needs?

(for example, to feedback?)

on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments online. Telephone consultations were also available.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed. Patients who contacted the practice when it was closed heard an answerphone message giving the telephone number they should ring depending on the circumstances such as NHS111 or a local out of hours GP service.

Longer appointments were available for those who needed them such as patients with a learning disability, those with long-term conditions or those with several health issues to discuss. Patients over 75 had a named GP. However, some patients aged over 75 told us that they did not always get to see their GP, particularly if the appointment was at short notice. Home visits were made to those patients who needed one.

Patient comment card feedback was generally positive regarding access to the service. However, some patients did express concerns regarding telephone access and seeing the GP of their choice. Results of the 2014 national patient survey showed that 54% of the patients who responded found it easy to get through to the practice by telephone. This compared with the Waltham Forest practice average of 63%. The practice's January 2014 survey indicated that 43% of patients responding had found it difficult to get through to the practice by telephone. Practice staff told us that they were aware of these concerns. We noted that in September 2014, following PPG concerns about telephone access, the practice had introduced online appointments booking and repeat prescriptions. We were told that that the aim was to relieve pressure on the telephone system. At the time of our inspection, it was too early to identify any positive impact of these changes although none of the twenty two patients we spoke with expressed concern regarding accessing the service by telephone. Comment card feedback was positive regarding early morning appointments available from 7.00am on Monday to Friday. This was particularly important to those patients with work commitments.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. A designated member of staff was responsible for handling all complaints made to the practice. Information was available to patients in the reception area and on the practice website. This included advice on how patients could escalate complaints to NHS England. However, only eleven of the twenty one patients we spoke with were aware of the process to follow if they wished to make a complaint. One patient who had used the complaints procedure told us that the issue had been resolved to their satisfaction.

The practice collated complaints on an annual basis. We looked at the latest report (2013/14) and saw that the 21 complaints had been made, with an approximately even divide between "administration" and "clinical" issues. We saw evidence of how complaints were used to improve the service such as the measures introduced to relieve the pressure on the telephone system.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver good quality patient-centred care and treatment, to understand and meet patients' needs and involve them in decisions about their care and treatment. We spoke with a range of staff including reception staff, nursing staff and GPs; all of whom described a patient-centred approach to delivering care. We did not see evidence of a business plan but our discussions with staff and our review of staff and clinical meeting minutes highlighted the practice's focus upon good quality patient centred care and treatment. We also noted that the practice's values were displayed in staff offices and in patient areas.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at nine of these policies and procedures and saw that most had been reviewed within the last twelve months. We did not see a record confirming that staff had read the policies but staff we spoke with demonstrated familiarity and understanding of the policies. For example, the practice manager's description of how they would escalate a safeguarding vulnerable adults concern was consistent with the practice's safeguarding policy; and the medical care practitioner's explanation of how they would deal with a sharps injury was also consistent with practice policy.

The practice had carried out various clinical audits triggered by latest best practice and research. However, we did not see evidence of a planned programme of clinical audit being systematically used to improve outcomes for patients. We noted that clinical performance meetings were held every six to eight weeks to review performance and take action as necessary.

Leadership, openness and transparency

Records showed that monthly team meetings took place and we saw that leadership issues such as senior staff changes were discussed and communicated throughout the practice. Staff told us that there was an open culture at the practice and that they felt comfortable raising issues at team meetings. We saw evidence that senior GPs encouraged good working relationships among staff, so that they felt valued and supported. For example, the practice's salaried GP and trainee GP (also known as a registrar) spoke positively about effective leadership and the support available at the practice. We also saw that the significant events procedure was used to provide positive feedback to staff. We noted that the practice was a post graduate teaching practice.

The practice was transparent, collaborative and open about performance. For example, recent clinical meeting minutes showed that QOF performance was regularly reviewed; for example evidence of reminders to staff to ensure that the smoking status of asthmatic patients was recorded.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice's January 2014 patient survey highlighted some patient dissatisfaction with 43% of responding patients having found it difficult to get through to the practice by telephone. The practice was able to demonstrate how it had acted on these concerns (for example the recent introduction of online booking and repeat prescriptions).

The practice had an active "virtual" patient participation group (PPG) of approximately 88 patients contacted by email. The PPG had developed an annual action plan with the practice and we saw evidence of how the practice had acted on the group's concerns (for example the introduction of a patient self-check in machine providing approximate waiting times for reach clinician).

Records showed that the practice had identified that Black and minority ethnic patients were under represented on its PPG. However, we did not see evidence of an action plan to address this under representation.

The practice generally received staff feedback through monthly team meetings. Staff told us that they that involved and engaged in decisions about delivering care and treatment.

Management lead through learning & improvement

Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. For example, one partner GP had recently attained a GP appraiser qualification. We noted

Are services well-led?

Good

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

that external speakers regularly attended the practice's clinical and business planning meetings to speak on topics such as benefit maximisation for people living in vulnerable circumstances.

There was a strong focus on continuous learning and improvement at all levels. Clinical staff attended a range of forums including the local CCG practice nurses forum and national NHS Alliance and Royal College of General Practitioner policy groups. Staff told us this allowed them to incorporate latest clinical best practice into patient care and treatment. We noted that lessons learnt from significant events and other incidents were available to all staff.