

# Dr Bhupinder Kohli & Ms Susan Paul

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Bhupinder Kohli & Ms Susan Paul's practice on the 11 June 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to the recruitment of staff.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

# Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice engaged in funded projects by the Department of Health such as the GP champions for youth working with Newham Asian Woman's Project to provide support to young people in accessing primary medical services. The lead GP met with local groups of young people as a speaker to explain how to use the NHS online services. The practice put up messages on their waiting room plasma screens to improve the confidence of young people to encourage them to make contact and communicated messages about respecting confidentiality and access to contraception advice.

- Governance and performance management arrangements were proactively reviewed and reflected best practice.

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

Importantly the provider must:

- Ensure that locum GPs who work at the practice receive Level 3 child protection training.
- Ensure that recruitment checks have been completed for staff before the start of their employment.

In addition the provider should:

- Ensure non-emergency medication is not stored with the emergency medicines and ensure all medication is within its expiry date.

**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 as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Significant events were discussed routinely at both clinical and practice meetings.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example there were concerns regarding the lack of recruitment checks completed for staff before they started employment and we did not see written evidence to confirm that locum GPs received Level 3 child protection training.

**Requires improvement**



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's' needs were assessed and care was planned and delivered in line with current legislation. Staff were committed to working collaboratively and people who had complex needs were supported to receive coordinated care. There were efficient ways to deliver more joined up care to patients. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice. Staff appraisals and personal development plans were in place for all staff.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were all offered an annual physical health check. Similar mechanisms for identifying 'at risk' groups were used for patients who were carers, obese, experiencing mental ill health and those receiving end of life care. These groups were offered further support in line with their needs and were offered advice on how to access support networks.

**Good**



### Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The

**Good**



# Summary of findings

data from the GP Patient Survey 2014 told us patients had confidence in the clinical staff they saw. The majority of patients said they had confidence and trust in the last GP they saw or spoke to and said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with most stating the GP was good at listening to them. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness, respect and maintained confidentiality.

Notices in the patients' waiting room, told patients how to access a number of support groups and organisations.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. The practice responded quickly to issues raised and learned from complaints. The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Patients were provided with the contact details of The Independent Complaints Advocacy Services (ICAS) and the Patient Advice and Liaison Services (PALS) to support them with their complaints.

Good



## Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. All staff were aware of the practice's vision and understood what their responsibilities were in relation to providing a good quality service. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Older people were cared for with dignity and respect. The practice was responsive to their needs, and there was evidence of working with other health and social care providers to provide safe care. We found that older patients identified at risk of isolation were discussed at monthly clinical meetings as well as multi-disciplinary meetings to monitor their care and address the support they required as necessary. We found that 72% of patients aged 65 and older had received the seasonal flu vaccination. An avoiding Unplanned Admissions List was in place which was designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who were at high risk of hospital admission or re-admission. All these patients had a named GP.

Home visits were also made to older patients by the GPs and a designated practice nurse. There was evidence of learning and sharing of information to help improve care delivery. There were structured and meaningful discussions in meetings to resolve issues in a time-bound and effective manner.

Good



### People with long term conditions

The practice is rated as good for the care of people with long term conditions (LTCs). There was evidence of patients with LTCs receiving effective and responsive care. Clinical staff had the knowledge and skills to respond to the needs of patients with cardiovascular diseases, diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD).

There was a palliative care (end of life) register and patients on the register were discussed at the monthly palliative care meetings. Patients with suspected cancers were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that showed improvements to practice were shared with all clinical staff. Longer appointments were also available for 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. The practice was responsive to the needs of this group. There were suitable safeguarding policies and procedures in place, and staff we spoke with were aware of how to report any

Good



# Summary of findings

concerns they had. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Records demonstrated good liaison with partner agencies such as the police and social services. Clinical staff attended child protection case conferences and reviews where appropriate. The practice engaged in funded projects by the Department of Health such as the GP champions for youth working with Newham Asian Woman's Project to provide support to young people in accessing primary medical services. The lead GP met with local groups of young people as a speaker to explain how to use the NHS online services.

The practice offered a full range of immunisations for children, which included travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the Clinical Commissioning Group (CCG), and there was a clear policy for following up non-attenders by the named practice nurse. Appointments were made available outside of school hours for children and young people and we saw that premises were suitable for children and young people.

## **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). There was a variety of appointment options available to patients such as telephone consultations, on-line booking and extended hours. The practice was performing well in undertaking cervical smear examinations and performance for cervical smear uptake was higher than other practices in the CCG area. Patients who did not attend for cervical smears were followed up and the uptake for health and blood pressure checks for working age patients was high also compared to the national average.

**Good**



## **People whose circumstances may make them vulnerable**

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. Although steps had been taken to identify the possibility of abuse and prevent abuse from happening, the practice had not addressed gaps in safeguarding training for locum GPs and was not aware of the gaps. The practice had policies in place relating to the safeguarding of vulnerable adults and whistleblowing. Staff we spoke with were aware of their responsibilities in identifying and reporting concerns.

**Good**



# Summary of findings

The practice had numerous ways of identifying patients who needed additional support. 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.

Notices in the patient waiting room, told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were told carers could also access a support service available at the practice.

## **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 provided a caring and responsive service to people experiencing poor mental health.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice worked closely with the local mental health team and effectively implemented joint working with the lead community psychiatric nurse. All clinical staff had received training in the Mental Capacity Act 2005 and were able to demonstrate an understanding of key parts of the legislation and describe how they implemented it in their practice.

**Good**





# Summary of findings

## What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP Patient Survey 2014 and a survey of 34 patients undertaken by the practice in 2014. These highlighted that patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw. For example, out of 102 patients who completed the survey, 90% said they had confidence and trust in the last GP they saw or spoke compared to the CCG average of 92%. Patients were

positive about their experience during consultations with GPs with 82% practice respondents said their GP was good at listening to them, describing their experience as very good Compared to the CCG average of 83%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and 22 patients had made positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Ten comments cards included negative comments which highlighted they did not always find it easy to get through on the phone and found it difficult to make an appointment.

## Areas for improvement

### Action the service **MUST** take to improve

- Ensure that locum GPs who work at the practice receive Level 3 child protection training.
- Ensure that recruitment checks have been completed for staff before the start of their employment.

### Action the service **SHOULD** take to improve

- Ensure non-emergency medication is not stored with the emergency medicines and ensure all medication is within its expiry date.

## Outstanding practice

- The practice engaged in funded projects by the Department of Health such as the GP champions for youth working with Newham Asian Woman's Project to provide support to young people in accessing primary medical services. The lead GP met with local groups of young people as a speaker to explain how to use the NHS online services. The practice put up messages on their waiting room plasma screens to improve the

confidence of young people to encourage them to make contact and communicated messages about respecting confidentiality and access to contraception advice.

- Governance and performance management arrangements were proactively reviewed and reflected best practice.

# Dr Bhupinder Kohli & Ms Susan Paul

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, and included a GP and a practice manager who were granted the same authority to enter registered persons' premises as the CQC inspector.

## Background to Dr Bhupinder Kohli & Ms Susan Paul

Dr Bhupinder Kohli & Ms Susan Paul's practice is situated in Manor Park in London and is situated within NHS Newham Clinical Commissioning Group. The practice holds a Personal Medical Services contract (Primary Medical Services agreements are locally agreed contracts between NHS England and a GP practice) and provides a full range of enhanced services including adult and child immunisations, learning disabilities services, minor surgery and remote care monitoring.

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

The practice had a patient list of just over 11,000 at the time of our inspection.

The staff team at the practice included one senior GP, nine salaried GPs, one GP trainee, four practice nurses and four trainee healthcare assistants and a team of administrative staff. The GPs comprised of four male and six female GPs (all working a mix of full time and part time hours).

Dr Bhupinder Kohli & Ms Susan Paul's practice was an approved training practice for GP Registrars.

The practice was open between 08:30 and 18.30 Monday to Friday. Appointments were available all day and the practice did not close during the day. Extended hours surgeries were offered at the following times, from 18.30 to 20.00 on Monday weekdays and every Saturday from 9.00 to 12.00 noon. To assist patients in accessing the service there was an online booking system, and text message reminders for appointments and test results. Urgent appointments were available each day and GPs also completed telephone consultations for patients. The out of hours services were provided by a local deputising service to cover the practice when it was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on their circumstances. Information on the out-of-hours service was provided to patients on the practice website as well through posters and leaflets available at the practice.

The practice had a higher percentage than the national average of people with a long standing health conditions (54.6% compared to 54.0%); and a higher percentage than the national average of people with health related problems in daily life (63.4% compared to 48.8%). The average male and female life expectancy for the Clinical Commissioning Group area was below the national average for males and in line with the national average for females.

# Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

## Why we carried out this inspection

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

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

## How we carried out this inspection

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 carried out an announced visit on 11 June 2015. During our visit we spoke with a range of staff such as three of the GPs, practice nurses, practice management and administrative staff. We spoke with four patients. We reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

# Are services safe?

## Our findings

### Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, they reported incidents and used 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. Significant events were discussed in meetings and we saw minutes to confirm this. For example we saw one recorded significant event where the wrong prescription pad was taken on a home visit. The practice changed its policy regarding practice prescriptions and its storage procedures.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two 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. We reviewed records of nine significant events that had occurred during the last 1 year and saw this system was followed appropriately. Although significant events were discussed routinely at clinical and non-clinical meetings, they were not a standing item on the practice meeting agenda and a dedicated meeting was not held monthly to review actions from past significant events. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the lead GP. There were records of significant events, and we were provided with a log dating from July 2014 to the present date. The lead GP showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example a patient on the palliative care list had expressed their wish to die at home which was recorded in

their care plan. A GP at the practice had made a referral to the Rapid Response Team and the patient was admitted to hospital where they later died. Action was taken to reduce the likelihood of the event reoccurring by the practice sharing electronic records with the Rapid Response Team to ensure the wishes of patients on the palliative care register were communicated.

National patient safety alerts were disseminated by email and then placed onto the intranet. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at weekly clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. We saw Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and saw an alert on Ebola communicated to the practice.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that non-clinical staff had received relevant role specific training on safeguarding in both adults and children, except three members of staff who were booked to attend the next training. We were provided with written documents to evidence that all permanent clinical staff had received Level 3 child protection training and training in safeguarding adults. However, we did not find written evidence to confirm that the four locum GPs who worked at the practice on an ad hoc basis had received Level 3 child protection training. The practice was unaware of the training gaps.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed two dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency

## Are services safe?

and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plans. The practice kept a child protection and adult safeguarding register. The practice acknowledged that this figure was low and was in the process of working with the adult social care department to find ways of obtaining up to date safeguarding information to ensure correct the codes were entered into their computer system to accurately reflect the number of adults subject to safeguarding.

The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police, social services and health visitors. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed. Safeguarding was a standing agenda item at the monthly multi-disciplinary meetings and weekly clinical meetings. We saw evidence of patients experiencing domestic abuse being referred to local support services, discussion of high risk children on the child protection register, homeless patients referred to social services in need of housing support and adult safeguarding referrals being made to the adults safeguarding teams.

There was a chaperone policy, which was visible on the waiting room TV plasma screen, in consulting rooms and on the practice web site. (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). All nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had undertaken training and understood their responsibilities when acting as

chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks, (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

### Medicines management

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

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

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

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked three anonymised patient records which confirmed that the procedure was being followed.

The practice did not have any controlled drugs.

### Cleanliness and infection control

We observed the premises to be clean and tidy and were provided with written cleaning logs to evidence that cleaning was taking place on a daily basis. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

# Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. 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.

The practice had a lead for infection control who was one of the practice nurses who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. She had attended infection control training in March 2014 and required an update as the training was out of date, which was brought to the providers attention. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years with the last audit taking place in September 2014 and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice had undertaken a risk assessment for legionella in May 2015 and had decided that the risk was sufficiently low to make formal testing unnecessary.

## Equipment

Staff we spoke with told us they had the 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 in June 2014. A schedule of testing

was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer all calibrated annually.

## Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the recruitment files for four locum GPs, one practice nurse and a member of the reception team who had recently been recruited. We found that appropriate recruitment checks had not been undertaken prior to employment by the practice. For example, for the four locum GPs that the practice recruited independently and not through a recruitment agency, did not have two references and completed application forms for them which would have included an employment history. Two references were also missing for the practice nurse. Only one reference had been obtained for the reception member of staff. Proof of identification and the appropriate checks through the Disclosure and Barring Service had been completed. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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

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

## 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, fire safety, the environment, medicines



## Are services safe?

management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. We saw that any risks and health and safety were standing agenda items at clinical and non-clinical staff meetings. There had not been any issues raised in the minutes we reviewed of meetings in May 2015.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. For example, we saw that additional GP cover was arranged following bank holidays and locum GPs were booked in advance to cover staff annual leave. There was also a risk log on the practice intranet which staff had access to and could record risks and their concerns which were then assigned to a manager to action. Risks associated with service and staffing changes both planned and unplanned were included on the log. The meeting minutes we reviewed showed risks were discussed at clinical and practice meetings.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

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. However, we did find a non-emergency medication, metoclopramide which had expired in January 2015 stored with the emergency medication and this brought to the provider's attention. The practice immediately arranged training for the nurses in charge of checking the medication and placed the emergency drugs box in sealed packaging to identify any unauthorised access. An audit of the emergency medication was completed on the 15 May 2015 which evidenced all the medication was in good order.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan was last reviewed in 2015.

The practice had carried out a fire risk assessment in January 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could 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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with three GPs and a nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and were in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes received regular health checks and were being referred to other services when required. We found 86% of mental health patients had received a health check and had care plans in place. Feedback from patients confirmed they were referred to other services or hospital when required. For example, patients on depot injections were being transferred from hospital care to the practice to ensure continuity of care. The practice effectively implemented joint working and met with the lead community psychiatric nurse on a monthly basis.

The GPs and nurses supported each other to provide care in specialist clinical areas such as diabetes, heart disease, asthma, chronic obstructive pulmonary disorder (COPD) and cardiovascular disease. The nurse told us the GPs were always there to provide advice and support. The practice used the choose and book system for standard referrals and the GPs followed national standards for two week wait

urgent referrals for suspected cancer. Patients we spoke with commented that referrals were always made in a timely manner and the GPs checked that they had attended their appointments with the relevant specialists.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

### Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the management to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us 15 clinical audits. The practice showed us two completed clinical audits that had been undertaken in the last year and the changes to treatment or care that were made where needed. This first audit linked to Diabetic Retinopathy Screening. The positive changes related to improving DNA rates for retinal screening by actively checking if patients attended the appointments and therefore reducing complication rates. The second completed audit was a Dementia Drug audit completed with the patients at a Nursing Home the practice was linked to. The first audit cycle highlighted the practice had to establish categories of severity, to ensure they had the full information before initiating diagnosis and severity and to follow up all patients diagnosed with dementia. A second clinical audit was completed one year



# Are services effective?

## (for example, treatment is effective)

later which demonstrated that the practice had implemented the improvements for all of its patients diagnosed with dementia at the home by writing to their specialists to obtain the severity of their condition and had invited patients for review to establish if referrals back to specialist services were required.

Other audits included an emergency admissions internal review, an audit on osteoporosis, on newer hypoglycaemics-Gliptins, Glitazones and GLP1 mimetics, cancer referral, mental health, asthma, management of UTI in primary care, and a sip feed audit.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). It achieved 100% of the total QOF target in 2014. For example the practice met all the standards for QOF in asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease, dementia, depression, epilepsy, heart failure, hypothyroidism, osteoporosis, palliative care, rheumatoid arthritis and stroke. It achieved most of the standards for diabetes (achieving 95.5% out of 102.23 points). Performance for mental health related and hypertension QOF indicators was better than the national average with the practice achieving all of the 40 points and was 9.6 % above the national average. The dementia diagnosis rate was above the national average with the practice achieving all of the 26 points.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. We looked at the medical records for three mental health

patients and found appropriate medication had been reviewed and prescribed. The IT system flagged up relevant medicine alerts when the GPs were prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs reviewed the use of the medicine in question. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This was a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example the local CCG provided a lot of data and feedback to local practices and a CCG wide network incorporating this feedback and a lot of other aspects such as policies was in place. For example, the practice compared its anti-biotic prescribing data to CCG data.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice had between 20 and 30 patients on the register which was continuously updated.

### Effective staffing

Practice staff included one senior GP, nine salaried GPs, one GP trainee, four practice nurses and four trainee healthcare assistants and a team of administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory training courses such as annual basic life support, safeguarding adults and chaperoning, with the exception of four locum GPs who had not received Level 3 child protection training. We noted a good skill mix among the GPs with one GP having an additional certificate in fitting contraceptive devices such as IUDs and coils. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

All GPs were up to date with their yearly continuing professional development requirements and three had been revalidated in January 2015 and one was due their revalidation in 2016, three in 2018 and three in 2019. This is a process where every GP is appraised annually, and undertakes a fuller assessment called revalidation every

# Are services effective?

## (for example, treatment is effective)

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.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. We reviewed five staff files, which confirmed this. Our discussions with clinical staff confirmed that the practice was proactive in providing training and funding for relevant courses, such as cytology, contraceptive and sexual health updates, child immunisations and travel, which the practice nurses had attended.

### Working with colleagues and other services

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

The practice worked with other service providers to meet patient needs and manage complex cases. It held clinical multidisciplinary team meetings once a month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

### Information sharing

The practice used several electronic systems to communicate with other providers. 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. Electronic systems were also in place for making referrals;

the practice used the Choose and Book system, which enabled patients to choose which hospital they would like to be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident & Emergency (A&E) department. The practice was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also put systems in place for patients to access their own medical records online and told us 1,000 patients had registered to access their records.

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

### Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this legislation. All clinical staff had received training in the Mental Capacity Act 2005. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. These processes highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. These helped clinicians to identify children aged under 16 who had the legal capacity to consent to medical examinations and treatment.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

### Health promotion and prevention

The practice had met with the Public Health team from the Clinical Commissioning Group to discuss the implications

# Are services effective?

## (for example, treatment is effective)

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

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

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and had 95 patients on the register who were all offered an annual physical health check. The practice had a palliative care register of three patients and had monthly internal as well as external multidisciplinary meetings to discuss the care and support needs of patients and their families.

We found that 88.6% of patients with hypertension in whom the last blood pressure reading measured

150/90mmHg or less had received a blood pressure check. Of the patients who required a smear test in the last five years, 84.4% had been seen which was above the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was a named nurse responsible for following up patients who did not attend screening.

Patients were given support to stop smoking and QOF data showed us that 97.27% of patients had their smoking status recorded. There was an asthma register and 76.1% of

patients had an asthma review in the last 12 months. The practice met all the minimum standards for QOF in diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD). The practice performance was 5.5% above the CCG average. Similar mechanisms of identifying 'at risk' groups were used for patients who were identified as carers, were obese, those receiving end of life care and those who experienced poor mental health. These groups were offered further support in line with their needs and offered advice on support networks.

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 for all childhood immunisations was above average for the CCG, for example 87.6% of children aged 24 months had received an MMR vaccination compared to the CCG average of 84.7%; 75.9% of 5 year old children had received the DTaP/IPV Booster compared to the CCG average of 69.1%.

There was a sexual health service including the fitting of coils and implants. The practice also provided occupational health and travel services. Patients were able to access a range of information via the practice website. This included guidance on long term conditions such as asthma, heart disease, diabetes; epilepsy, hypertension, respiratory disease, family health and minor illnesses.

The practice supported its students and working age patients by offering extended opening hours, telephone appointments and online bookings.

Data from QOF indicated the practice exceeded the national average for having a comprehensive care plan in place for patients with schizophrenia, bipolar affective disorder and other psychoses achieving 94.4% compared to the national average of 86.09%. The practice had reviewed 80 % of its patients diagnosed with dementia in a face to face review in the preceding 12 months, compared to the national average of 83.83%.

# 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 GP Patient Survey 2014 and a survey of 34 patients undertaken by the practice in 2014. These highlighted that patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw. For example, out of 102 patients who completed the survey, 90% said they had confidence and trust in the last GP they saw or spoke with and 75% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with GPs and 82% practice respondents said their GP was good at listening to them, describing their experience as very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and 22 patients had made positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Ten comments cards included negative comments which highlighted they did not always find it easy to get through on the phone and found it difficult to make an appointment.

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 treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped patient information to be kept private. Patients could speak to reception staff in a private room and notices were displayed in the reception areas informing patients of this option.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would conduct an investigation and any learning identified would be shared with staff.

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

### Care planning and involvement in decisions about care and treatment

The GP Patient Survey 2014 and comment cards we received showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the GP Patient Survey showed 68% of respondents said the GP involved them in care decisions and 73% of patients felt the GP was good at explaining treatments.

Four patients we spoke to on the day of our inspection two of which were also members of the Patient Participation Group (PPG), told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They 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. Patient feedback on CQC comment cards was also aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language. We saw a notice in the reception areas informing patients this service was available. Sign language services were available to support patients with a hearing disability.

The practice engaged in funded projects by the Department of Health such as the GP champions for youth working with Newham Asian Woman's Project to provide support to young people in accessing primary medical services. The lead GP met with local groups of young people as a speaker to explain how to use the NHS online services using a smartphone, to improve access and quality of health care access to young people in the wider community in Newham and not just at their practice. During these meetings, this was achieved by connecting a

## Are services caring?

mobile phone to a projector and going through a number of NHS applications on how to access a GP, how to check symptoms and how to use the NHS. As result of being involved with the project the practice had also increased the awareness of their own staff team in supporting issues affecting young people and their perceived fear of accessing health care. The practice put up messages on their waiting room plasma screens to improve the confidence of young people to encourage them to make contact and communicated messages about respecting confidentiality and access to contraception advice and that their confidentiality would not be breached. They had also partnered with Newham Asian Woman's Project to train their staff on domestic violence.

The practice told us they used the Department of Health's 'You're Welcome' criteria to provide young people friendly health services. The practice also had a visiting mental health specialist nurse providing clinics reviews and follow ups for patients with poor mental health.

### **Patient/carer support to cope emotionally with care and treatment**

The practice website offered patients information as to what to do in time of bereavement and also referred them to a local counselling service.

Notices in the patient waiting room, advised patients how to access a number of support groups and organisations and this information was also available on the practice website. The practice's computer system alerted GPs if a patient was also a carer and the practice assessed carers' needs and kept a register of these individuals.

We saw that older patients identified as at risk of isolation were discussed at clinical meetings as well as to address the support they required.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

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

We were informed that there was close liaison between the practice and the CCG, particularly as the one of the practice partners was a board member of the CCG. There was documented evidence to confirm that discussions with the CCG had led the practice to implement service improvements or manage delivery challenges to its population.

The practice had not actively promoted its Patient Participation Group (PPG) which had met twice since June 2014 and last met in March 2015. We were informed the group comprised of eight people and the practice struggled with getting patients to attend. When speaking to two members of the group they informed us that they had not attended a meeting for more than six months. We did not see active advertisements in the reception areas or on the practice website informing patients how they could join the group. The practice management informed us that they had employed a communication and engagement officer to promote the PPG group as well as to promote communication and engagement between clinical staff and patients.

The four patients we spoke with said they were very happy with the efforts the practice had taken to involve them in their care. They felt that their concerns were listened to and suggestions were always implemented and they had seen some marked improvements at the practice in the past. For example, they informed they had seen improvements in the telephone call back service and informed the GP always called and gave advice accordingly.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We saw the practice had identified the numbers of patients on the learning disability register, those experiencing poor mental health, patients who were carers, children and adults on the vulnerable risk

register and patients with dementia. The needs of these different groups were discussed at the range of meetings that took place at the practice with internal and external clinical staff.

The practice had provided equality and diversity training to all its staff team. Equality and diversity was regularly discussed at staff appraisals, supervisions, practice team meetings and was covered in staff policies and procedures.

The premises and services had been adapted to meet the needs of people with disabilities and there was pram and wheelchair access throughout the premises and there was a lift in place. As well as an accessible toilet there were also baby changing facilities. The practice was situated on the first floor with all services for patients operating from this floor.

### Access to the service

The practice was open between 08:30 and 18.30 Monday to Friday. Appointments were available all day and the practice did not close during the day. Extended hours surgeries were offered at the following times, from 18.30 to 20.00 on Monday weekdays and every Saturday from 09.00 to 12.00. To assist patients in accessing the service there was an online booking system, text message reminders for appointments and test results. Urgent appointments were available each day and GPs also completed telephone consultations for patients. The out of hours services were provided by a local deputising service to cover the practice when it was closed.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were 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 their circumstances. Information on the out-of-hours service was provided to patients on the practice website as well through posters and leaflets available at the practice.

Longer appointments were available with a named GP, nurse or healthcare assistant for people who needed them, for example those with long-term conditions. Home visits were made to those patients who needed one. For

# Are services responsive to people's needs?

(for example, to feedback?)

example, a house bound register was maintained to do home visits and older patients and those with long term conditions were also visited at home by the GPs and a designated practice nurse.

The GP Patient Survey 2014 highlighted low numbers of patients satisfied with the appointments system with 52% of patients who described their experience of making an appointment as good and only 54% informing that they found it easy to get through to the surgery by phone. The practice survey also raised patient concerns with the lack of appointments available. The practice in response to the surveys had implemented an action plan and had added more telephone sessions to give patients the option of speaking to a GP on the day and had trained nurses to complete triage sessions. The PPG group members confirmed that although getting through on the phone and getting an appointment was sometimes difficult it also said that things were getting better and if you had to be seen on the day they would always fit you in.

## Listening and learning from concerns and complaints

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

in the practice. Patients were also provided with the contact details of The Independent Complaints Advocacy Services (ICAS) and the Patient Advice and Liaison Services (PALS) to support them with their complaints.

We saw that information was available to help patients understand the complaints system such as posters displayed in the reception area. Four members of the PPG we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had recorded eight complaints between April 2014 and March 2015. They were satisfactorily handled and were dealt with in a timely way which was in accordance with the practice's complaints policy. Each complainant was written to, discussing their complaint in detail.

All complaints including verbal complaints were thoroughly recorded and we saw evidence of openness and transparency when dealing with complaints. Verbal complaints were recorded in writing to ensure they were not missed and were also responded to in writing.

The practice reviewed complaints on an on-going basis by discussing complaints at its practice and clinical meetings to detect themes and trends and to ensure lessons were learned from individual complaints. We saw from the minutes that complaints were routinely discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

# 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 high quality care and promote good outcomes for patients. Its strategy was to develop a federated approach to general practice in Newham. The practice had a statement of intent which was displayed in the patient waiting area which set out the practice's aims to provide high quality primary care service for patients in Newham.

We spoke with eight members of staff and they all knew and understood the vision, values and knew what their responsibilities were in relation to these.

### Governance arrangements

The practice used information technology to become a paperless practice. The practice used their intranet (called their OneRoom) as the access point for all policies, procedures, training materials and for staff to manage their training. The intranet was available to staff through the internet which could be accessed from any location. The system also allowed staff to view staff rotas, book annual leave or notify the management team of any important information. For example, staff could log positive feedback or whistleblowing information onto the system and immediately become accessible to the management team to action. The system had enabled the management team to manage and support their staff effectively with speed through the computer system.

The practice had a number of policies and procedures in place to govern activity on the intranet and we reviewed a number of policies, for example the induction policy and recruitment policy, which were in place to support staff. They were detailed and provided appropriate guidance for staff. We were shown the staff handbook that was available to all staff, which included sections on equality, harassment and bullying at work. The practice had a whistleblowing policy and all policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure which included a central management team made up of managers and clinical staff including GPs and practice nurses in lead roles. For example, there was a lead for human resources, finance, performance operations, nursing, medical teams, infection control, safeguarding, medication management

audits, health and safety, fire safety, information governance and patient complaints. The management focused on their key areas to drive improvement within the practice as well as other practices within the federation.

We spoke with eight members of staff who told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff were encouraged to learn and develop their careers.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. This was reflected in the meeting minutes we reviewed.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice showed us 15 clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. The practice showed us two completed clinical audits that had been undertaken in the last year and the practice was able to demonstrate the changes resulting since the initial audits.

This first audit linked to Diabetic Retinopathy Screening and the positive changes related to improving DNA rates for retinal screening by actively checking if patients attended the appointments and therefore reducing complication rates. The second completed audit was a Dementia Drug audit completed with the patients at the Nursing Home the practice was linked to which demonstrated follow up reviews were completed for all patients diagnosed with dementia and there was better communication with the patient's specialist to obtain information on the severity of their condition.

The practice had robust arrangements for identifying, recording and managing risks. The management showed us the risk log, which addressed a wide range of potential issues, such as risks to the building, staff, dealing with emergencies and equipment. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at clinical and non-clinical meetings.



# Are services well-led?

Good 

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

The practice also had a health and safety policy. Health and safety information was on the practice intranet for staff to see.

The practice held monthly practice meetings which discussed governance. We looked at minutes from the last six meetings and found that performance, quality and risks had been discussed.

## **Leadership, openness and transparency**

We saw from meeting minutes that team meetings were held monthly and clinical meetings on a weekly basis. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings.

## **Seeking and acting on feedback from patients, public and staff**

The practice had gathered feedback from patients through its practice patient surveys and complaints received. Four patients we spoke with said they were very happy with the efforts the practice had taken to involve patients in their care. They felt that their concerns were listened to and suggestions were always implemented and they had seen some marked improvements at the practice. For example, they informed they had seen improvements in the telephone call back service and informed the GPs always called and advised accordingly. However, the practice had not actively promoted its PPG group and meetings were not taking place regularly. The practice management had already acknowledged this and informed us that they had employed a patient engagement officer to promote the PPG group.

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.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular appraisals took place which included a personal development plan for staff. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared the findings with staff at meetings. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were not a standing item on the clinical and practice meeting agenda but evidence from written minute meetings confirmed that they were discussed at these meetings to review actions from past significant events and complaints. There was evidence that the practice learned from these and that the findings were shared with relevant staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. 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.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing  How the regulation was not being met: The registered person had not ensured that locum GPs working at the practice had received Level 3 child protection training, 18 (2).
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed  How the regulation was not being met: The registered person had not ensured that full recruitment checks had been completed for staff before the start of their employment, (3) (a).
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	