

St Bartholomew's Surgery

Quality Report

292a Barking Road East Ham London E6 3BA

Tel: 0208 472 0669

Website: www.st.bartholomewssurgery.gpsurgery.net

Date of inspection visit: 5 August 2014

Date of publication: 08/01/2015

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.

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	5
What people who use the service say	7
Areas for improvement	7
Outstanding practice	7

Detailed findings from this inspection

Our inspection team	8
Background to St Bartholomew's Surgery	8
Why we carried out this inspection	8
How we carried out this inspection	8
Detailed findings	10
Action we have told the provider to take	23

Summary of findings

Overall summary

St Bartholomew's Surgery is located in East Ham in the London borough of Newham, East London and has a patient list of approximately 9,600. Newham's health profile shows that it is worse than the England average and at or below the regional average on a range of indicators including substance misuse, recorded diabetes and incidence of tuberculosis (TB). The national index of multiple deprivation lists Newham as the second most deprived out of 326 local authorities in England.

The practice operates from one site. The staff team consists of five GP partners (one female, four male), one salaried GP (male), two practice nurses, one part time health care assistant, one practice manager and a team of reception and administration staff. During our inspection, we spoke with three GPs, two practice nurses, practice manager and reception staff.

All of the patients that we spoke with and those who completed comment cards were positive about the service they received at St Bartholomew's Surgery. During our inspection we observed that patients were cared for in a respectful and compassionate manner.

We noted that clinical staff met weekly to review patient progress. Meetings also routinely took place with other clinicians and the practice hosted or delivered a range of clinics which were relevant to the local health profile. These included ante natal and sexual health clinics.

The practice participated fully in Quality and Outcomes Framework (QOF) - a voluntary incentive scheme

rewarding practices for how well they care for patients. The framework was used to improve services and benchmark (or compare) the practice with other practices in the borough.

The practice has an above average number of patients aged over sixty five relative to Newham and is slightly below average regarding patients aged under eighteen. Poor mental health, recorded sexual health infections and diabetes are overly represented in the borough; and this is also the case at the practice level. During our inspection, we noted that the practice was responsive to the needs of its population group. Examples included screening programmes for patients at risk of developing diabetes and weekly ante natal clinics. We also noted that the practice hosted an outpatient clinic delivered by the local community mental health team and provided a weekly sexual health clinic.

The provider was in breach of regulations related to:

Requirements relating to workers

Infection control and cleanliness

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.

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 had systems in place for discussing patient safety issues with clinicians but opportunities for discussion with the wider staff team were infrequent and not formalised. The practice had a system for reporting, recording and monitoring significant events but we noted that the information collected was insufficient to enable learning from events. The practice had a GP safeguarding lead and staff had attended child protection and safeguarding vulnerable adults training. GPs had additionally attended advanced level 3 child protection training. The practice had systems in place to ensure staff coverage in the event of sickness or an emergency.

There were suitable arrangements in place to ensure that all medicines were handled, stored and administered safely. The practice used cleaning schedules but we noted inconsistencies. The practice had a business continuity plan but we were advised that it needed to be updated.

Disclosure and Barring Service (DBS) checks had not been carried out for administrative staff and there was also no evidence that this decision was based upon a written risk assessment of their duties. After our inspection, the practice advised us that administrative staff did not come into contact with vulnerable patients on a one to one basis and were therefore not DBS checked.

Records showed that equipment such as blood pressure machines and weighing scales had been calibrated within the last twelve months but we also noted that portable appliance testing (PAT testing) had not been undertaken. Fire extinguishers and fire blankets were overdue their annual service. Infection control audits did not take place.

Are services effective?

Patients received services that were effective although some areas required improvement. Weekly clinical meetings included discussions on changes to guidance and best practice including National Institute for Health and Care Excellence (NICE).

The practice had systems in place to disseminate patient safety alerts but it was not clear who had lead responsibility. Staff appraisal systems were in place although we noted that non clinical staff supervision meetings were not documented. The practice was able to evidence partnership working with other clinicians and health promotion activity took place which reflected the health profile of the local community.

Summary of findings

Are services caring?

Patients received services that were caring and we noted that patient feedback was uniformly positive. Members of the practice's Patient Participation Group (PPG) told us that staff were caring and respectful. Consistent themes of patient comment card feedback were that staff listened and that they were compassionate.

Patient feedback on how they were involved in decisions about their care was generally positive although some patients told us there was sometimes insufficient time to discuss matters with their GP. The national GP Patient 2013 survey reported that 70% of patients would recommend the surgery to someone new to the area. This was better than the local CCG average.

Are services responsive to people's needs?

Patients received services that were responsive. A range of clinics and services were delivered from the practice including diabetic, antenatal and sexual health clinics which were responsive to the local health profile. GPs participated in multidisciplinary meetings where the condition of patients was reviewed with other clinicians. The practice gave examples of how it had taken on board Patient Participation Group (PPG) feedback in delivering the service. Patients were offered a mixture of appointments at the practice. For example, any patient arriving at the practice by 10am was seen by a GP that day. The national GP Patient 2013 survey reported that 87% of patients surveyed said that the last appointment they got was convenient. This was better than the local CCG average.

Are services well-led?

Patients received services that were well led. Staff told us that they felt the practice was well led and had an open culture. One of the senior GPs told us that the practice vision was best described as a "commitment to providing responsive clinical care." Minutes of weekly clinical meetings evidenced that GPs discussed QOF performance across a range of clinical areas. PPG members spoke positively about how the practice acted upon patient feedback. Annual staff appraisals took place and we noted that these included learning outcomes and targets. The practice had systems in place to identify and manage risk but we noted a lack of succession planning to manage risks associated with a senior GPs' planned retirement.

We also noted that although each GP led on a specific governance area (such as safeguarding or infection control) this was not documented. This meant that there was no lead person tasked with identifying and managing risk in these areas.

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 was responsive to the needs of older people. The practice was on one floor and we saw that it had a ramped entrance for wheelchair users. Space was limited but there appeared to be space for a wheelchair user to turn. Older patients spoke positively about how care was delivered. We noted that there was reserved seating for elderly patients in reception. Home visits were offered and patients over 75 had a named GP.

People with long-term conditions

GPs participated in multidisciplinary meetings where patients' conditions were reviewed. Patients with long term conditions spoke positively about how the practice provided sufficient information to be able to make informed decisions about managing their condition. Practice nurses and some GPs had attended nationally recognised specialist training in chronic disease management.

Mothers, babies, children and young people

The practice was responsive to the needs of mothers, babies, children and young people. For example, before our inspection, we noted that Newham has the highest birth rate in England and on inspection we saw that the practice provided weekly antenatal clinics to pre-expectant mothers. GPs had attended advanced level 3 child protection training and we also saw evidence of multidisciplinary meetings with other clinicians such as health visitors. Before our inspection, we noted that the proportion of people below 40 years was above the England average. During the inspection, we noted that the practice ran a weekly drop in sexual health clinic to address the sexual health needs of its young population.

The working-age population and those recently retired

The practice was responsive to the needs of working aged people and those recently retired. Patients were offered a mixture of appointments at the practice from Monday to Friday 8:00am-6:30pm with extended hours appointments on Monday until 8.30pm. This meant that there was a choice of appointment times before and after work. We also noted that any patient who arrived at the practice by 10am was seen by a GP that day. Telephone consultations were available and appointments and repeat prescriptions could be made online.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care

The practice was responsive to the needs of people in vulnerable circumstances. We were told that sex workers who attended the practice's sexual health drop in clinic were also offered referral to local substance misuse agencies for specialist support. The practice provided annual health checks for patients with a learning disability and systems were in place to provide British Sign Language (BSL) interpreters to patients. Practice staff had also attended introductory BSL courses.

People experiencing poor mental health

The practice was responsive to the needs of people experiencing poor mental health. The practice hosted a weekly mental health community nurse pilot which enabled outpatients to be treated in familiar community settings rather than at a local hospital. We noted that multidisciplinary meetings included community mental health teams. Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA 2005) and their obligations to patients who lacked capacity.

Records showed that practice nurses were scheduled to attend MCA 2005 training in September 2014.

Summary of findings

What people who use the service say

During our inspection, we spoke with thirteen patients. They gave positive feedback on, for example, how they were treated by staff and the practice environment. Some of these patients were members of the practice Patient Participation Group (PPG) and gave examples of how staff listened to and acted upon patients' concerns.

We also reviewed thirty six 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 that they were compassionate.

We used existing patient feedback to inform our discussions with patients. For example, 2014 NHS Choices patient feedback was negative regarding reception staff. However, when we spoke with patients and reviewed comment cards, feedback was positive.

GP national patient survey 2013 data highlighted that 56% of patients were satisfied with the level of privacy when speaking to receptionists at the surgery (slightly below the local CCG average). Patients we spoke with also expressed dissatisfaction but added that staff did their best to ensure patients' privacy was maintained. We noted that privacy in reception had been discussed at a recent PPG meeting.

Patients told us that they felt involved in decisions about their care and treatment and that their questions were answered. This was consistent with GP 2013 national patient survey data which reported that 81% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments (slightly below the local CCG average).

Areas for improvement

Action the service **MUST** take to improve

- The practice was not undertaking infection control audits or using risk assessed cleaning schedules;
- Disclosure and Barring Service risk assessments for non-clinical staff had not taken place;
- The practice did not have protocols in place specifying clinical audit frequency or level of detail;
- Legionella testing had not been carried out;
- The practice did not have protocols in place for assessing and monitoring safety.

Action the service **SHOULD** take to improve

- Red fire extinguishers at the practice were overdue their service;
- The practice did not have a significant events policy and the form used to record significant events lacked the detail necessary to share learning;
- There were no hand gel dispensers in the reception area;
- Individual staff supervision meetings were not recorded;

Outstanding practice

Our inspection team highlighted the following areas of good practice:

- Any patient arriving at the practice by 10am was seen by a GP that day.

St Bartholomew's Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector**. The team included a GP and a variety of specialists: practice nurse, practice manager and an “expert by experience” patient engagement specialist.

Background to St Bartholomew's Surgery

St Bartholomew's Surgery is located in East Ham, London Borough of Newham in East London. Newham's health profile reveals that substance misuse, recorded diabetes, incidence of TB and acute sexually transmitted infections are significantly higher than the England average. Recorded prevalence of serious mental illness is also higher than the England average; reflecting factors such as homelessness and substance misuse.

Newham is the second most deprived borough out of the 326 local authorities in England. Latest census data shows an increasing population and also one that has a proportion of young people that is higher than the England average. Conversely, the overall prevalence of dementia in Newham is lower than the England average due to this younger population.

At the practice level, the practice has an above average number of patients aged over 65 compared to Newham and is slightly below average regarding patients aged under eighteen.

There is a higher than average proportion of Black and Minority Ethnic residents and also marked contrast within the borough. For example, life expectancy is 7.4 years lower for men and 6.6 years lower for women in the most deprived areas of Newham than in the least deprived areas.

St Bartholomew's Surgery is registered to provide the following regulated activities which we inspected: treatment of disease, disorder or injury diagnostic and screening procedures, family planning, maternity and midwifery services. The practice delivers primary medical services to 9,688 registered patients as at 31 March 2014. The staff team consists of five GP partners, one salaried GP, two practice nurses, part time health care assistant, practice manager and a team of reception and administration staff.

The surgery is open from 8:00am to 6:30pm Monday to Friday and offers an extended hours service with pre-bookable appointments on Mondays from 6:30pm to 8:30pm. Patients calling the practice out of hours are referred to the local out of hours provider as the practice has opted out of providing out-of-hours services to patients.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this practice 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

Detailed findings

and Social Care Act 2008, to look at the overall quality of the services, and to provide a rating for the services under the Care Act 2014. This practice had not been inspected before.

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

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 5 August 2014 between 10am and 7pm. During our visit we spoke with a range of staff, including GPs, practice nurses, practice manager and reception staff.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

Safe patient care

The practice had a system in place for reporting, recording and monitoring significant events although we noted areas for improvement. Significant event forms had been completed within the last 12 months. We were told that these forms were used as the basis for significant events discussions at weekly clinical meetings. However, we noted that they lacked sufficient detail to enable the practice to analyse, learn from events and take steps to minimise chance of reoccurrence. For example, it was not clear who had completed the forms and some were not dated. The practice did not have a significant events policy on file.

Learning from incidents

The practice had some systems in place for reporting safety incidents. However, the entire staff team only met every six months which meant there were infrequent opportunities to discuss patient safety issues as a team. We noted that weekly clinical meetings took place where patient safety matters were discussed but administrative staff did not attend these meetings. Shortly after our inspection, we were advised that the frequency of team meetings would be increased to every three months.

Safeguarding

The practice had a GP safeguarding lead and GPs had undertaken advanced Level 3 child protection training and shortly after our inspection we were advised that the practice nurses had undertaken Level 2 child protection training. Staff recognised the different types of abuse and knew how and to whom they would report concerns. Some non-clinical staff had received Level 1 children and vulnerable adult safeguarding training. The staff notice board included local safeguarding contacts and advised staff how to escalate a concern; and we noted that staff were familiar with this process. The practice also had a chaperone policy and this was publicised in reception and treatment rooms. We were told that practice nurses and reception staff undertook chaperone duties.

Monitoring safety and responding to risk

The GP staffing rota included annual leave, study days and unpaid leave for the next twelve months, which enabled staff numbers to be planned in advance. Rotas for practice nurses were planned three months ahead and non-clinical

staff one week ahead. We were told that if there was a clinical staffing shortfall, part time GPs would be asked if they were available to work the required extra hours. If this was not possible, a locum GP would be booked. The staffing rota in place ensured that the practice was able to respond to periods of increased demand such as during the winter period or at the start of summer holidays. We also noted that most administrative staff worked part time which meant flexibility regarding extra staff provision in times of high demand.

The practice had an emergency contingency plan but we were told it needed to be updated. For example, it referred to the local Primary Care Trust which ceased to exist in March 2013.

We were told that fire risk assessment had taken place in March 2013 by the landlord of the building but a copy of the fire risk assessment report was not available at the time of our inspection. We were also advised that the landlord was responsible for servicing fire equipment. However, when we looked at fire equipment we noted that fire extinguishers and fire blankets were overdue their annual service. The provider told us that they would immediately take this up with the landlord.

Medicines management

There were suitable arrangements in place to ensure that all medicines were handled, stored and administered safely. Checks were regularly made on the temperature of the fridge to ensure that vaccines and other medicines remained within the acceptable temperature range. We noted however, that the fridge was not “hardwired” into the power supply and had never undergone a portable appliance test (PAT test).

The practice did not dispense medicines directly to patients but a small quantity of emergency medicines were kept on the premises. These were within their expiration date and the practice had a system for conducting regular checks. The practice had recently received a “green” rating for a recent annual prescribing review led by the local CCG.

Cleanliness and infection control

One of the senior GPs was Infection Prevention and Control (IPC) lead for the practice. Consultation rooms had vinyl flooring and we saw that waste was segregated. Clinical waste was stored securely whilst awaiting collection.

Are services safe?

Clinical staff used personal protective equipment such as gloves and masks. Soap gel, disposable towels and laminated hand wash guidance were also located adjacent to hand wash basins.

We saw that the practice used cleaning schedules for areas of the practice but there was no evidence of prior risk assessments to determine cleaning frequency and intensity. We also noted cleaning schedule inconsistencies. For example, one consulting room's cleaning schedule recorded that window blinds had been dusted six working days before our inspection. However, on the day of inspection we noted that the blinds were dirty. We also saw cobwebs on waiting area display racks which was also inconsistent with cleaning schedule records. We noted that there were no hand gel dispensers in the reception area. A legionella risk assessment had not been carried out.

Reception staff explained how they received and handled specimen samples. They referred to the use of gloves and specimen bags but we did not see evidence of a written policy for handling specimen samples.

We observed that several chairs in treatment rooms and communal areas were fabric. We were advised that fabric chairs were steam cleaned every six months. However, Department of Health Infection Prevention and Control guidance advises against the use of fabric seating as it is pervious and therefore less easy to clean.

The practice was unable to demonstrate that they had carried out any infection control audits or that staff IPC training had taken place.

Staffing and recruitment

We were told that some reception staff acted as chaperones. However, we did not see evidence of Disclosure and Barring Service (DBS) checks or evidence that the decision not to have DBS checks for administrative staff was based upon a risk assessment of specific roles.

Dealing with Emergencies

Clinical and administrative staff had received basic life support training within the last 12 months. Emergency drugs were centrally accessible and within expiry date and we saw systems to ensure regular checks of expiry dates. The practice's emergency oxygen cylinder was full and within its expiry date.

Equipment

Records showed that equipment such as blood pressure machines and weighing scales (adult and infant) had been calibrated within the last 12 months. Portable appliance testing (PAT testing) had also not been undertaken although shortly after our inspection, we were told that PAT testing would take place by September 2014. The practice had a defibrillator on the premises but this was still in its packaging. Shortly after our inspection, we were advised that staff training had taken place and that the defibrillator was in service.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

GPs told us that they attended weekly clinical meetings with practice nurses and minutes showed that discussions took place at these meetings regarding changes to guidance and best practice such as National Institute for Health and Care Excellence (NICE). However, we noted that there was no clear process for disseminating information identified at this meeting (such as practice performance information or drug alerts) to the wider staff team.

We asked how patient safety alerts (for example drug recall information) were disseminated. We were told that when an email alert was received from NHS England or the local CCG it was printed and circulated to the practice GPs who were required to sign, confirming they had read the document. However, when we looked at a sample of patient safety alerts, we noted that some signatures were missing. An alert had recently been sent to all GPs in the borough regarding a specific drug but the practice could not evidence that the alert had been received or circulated to staff. The lack of a written protocol meant it was unclear who had lead responsibility for circulating the alert to staff.

Staff demonstrated an understanding of the Mental Capacity Act 2005 and their obligations to patients who lacked capacity. Records showed that practice nurses were scheduled to attend Mental Capacity Act 2005 training in September 2014.

Management, monitoring and improving outcomes for people

The practice had some systems in place for undertaking clinical audits. We noted that within the last 12 months, clinical audits had been carried out on two week cancer referrals. However, these were incomplete in that audit results were limited and it was unclear how they would be shared and improvements monitored.

The practice also participated in the Quality and Outcomes Framework (QOF - a voluntary incentive rewarding practices for how well they care for patients) to improve services and benchmark the practice with other practices in the borough. QOF performance highlighted for example that the practice's dementia care was in the top third for Newham practices.

We noted that QOF performance across a range of clinical areas was discussed at weekly clinical meetings. Discussions also included significant events, clinical audit results and peer reviews.

Practice nurses and some GPs had attended nationally recognised specialist training in chronic disease management. GPs regularly attended CCG locality meetings where they could participate in peer review and find out about CCG led projects to tackle local health inequality. For example, we were told that the practice had recently joined a CCG led tuberculosis screening project.

Staffing

All of the GPs and practice nurses had had an appraisal within the last 12 months. Practice nurses were appraised by a senior GP and non-clinical staff also received annual appraisal.

The practice manager told us that they had an "open door" policy and that non clinical staff received regular informal supervision. This was confirmed by staff. However, we noted that these meetings were not documented.

Non clinical staff were up to date regarding mandatory basic life support training and shortly after our inspection we were advised that they had attended safeguarding training.

Clinical staff were responsible for ensuring they were up to date regarding training and we saw evidence that continuing professional development took place. For example, practice nurses had attended nationally recognised training in chronic disease management. GPs told us they set aside dedicated weekly learning time and also advised that weekly practice clinical meetings and monthly CCG clinical meetings enabled them to further develop their clinical knowledge.

Working with other services

We saw evidence of collaborative working between practice staff and a range of clinicians including district nurses, health visitors and end of life nurses. The practice hosted services delivered by the midwifery team and other clinicians. A new consultant psychiatrist had also recently attended a practice clinical meeting to develop joint working opportunities. Where a need was identified, patients attending the practice's weekly sexual health clinic were offered referral to local substance misuse agencies for specialist support.

Are services effective?

(for example, treatment is effective)

Newham has the highest level of TB in Europe. To address this local issue, the practice was involved in a local CCG pilot project to screen for asymptomatic TB patients (i.e. patients carrying the disease but not displaying symptoms).

The practice hosted a weekly mental health community nurse pilot enabling outpatients to be seen in more familiar community settings rather than at the local hospital.

Health, promotion and prevention

A range of health promotion activity took place including ante natal clinics, sexual health clinics and smoking cessation. The practice routinely offered lifestyle advice to patients identified as at risk of diabetes and was also involved in a local Tuberculosis screening project. New patients were offered a consultation and all patients over forty were offered a health check. The reception area displayed patient information on conditions which were prevalent amongst the local community such as diabetes.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patient feedback on the NHS Choices website was negative regarding how reception staff treated patients (for example 8 out of 21 patients expressed concern about the helpfulness of reception staff and the practice's overall rating was 1½ stars out of six). During our inspection, we asked patients about their experience and we noted that feedback was uniformly positive. For example, when we met with members of the practice's Patient Participation Group (PPG) they told us that staff were caring and respectful; and other patients we spoke with expressed similar views. Patient comment card feedback was also positive with consistent themes being that staff were respectful, that they listened and that they were compassionate.

National GP patient survey 2013 also reported some negative feedback regarding patients' privacy in reception. We discussed this with patients and were told that although the reception area layout hindered privacy, reception staff always sought to ensure that patients' privacy was maintained. For example, we saw that patients waiting to be seen were requested to stand away from the reception desk whilst the patient in front was being seen. We also noted that there were facilities adjacent to reception where patients could speak in private.

The practice had a chaperone policy and this was publicised in reception and treatment rooms. We were told that practice nurses and reception staff undertook chaperone duties but they had not received training. However, shortly after our inspection we were advised that chaperone training had taken place.

We observed that staff interacted with patients in a respectful and compassionate manner. The GP national Patient Survey 2013 reported that 70% of patients who responded would recommend their surgery to someone new to the area (better than the local CCG average).

Involvement in decisions and consent

Patients told us that they felt involved in decisions about their care and treatment. They told us that their GP listened and that questions were answered. Some patients also fed back that they felt that there was sometimes insufficient time to ask detailed questions. However, they also told us that the practice nurse appointments times allowed them sufficient time to ask questions and make informed decisions about their care and treatment. This was consistent with the national GP patient survey 2013 results which reported that 81% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments (slightly below local CCG average).

Comment card feedback was also positive regarding clinical staff members' ability to listen and act upon patients' concerns. We saw that the reception area contained patient information on conditions, which were prevalent amongst the local community such as diabetes.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered or hosted a range of services in response to local health needs including weekly clinics for antenatal care, sexual health, asthma and diabetes.

We also saw evidence that clinical staff participated in multidisciplinary meetings with end of life nurses, district nurses and other clinicians to discuss the care and treatment of patients.

We asked the practice for examples of how they had responded to patient feedback. We were told that the practice had acted on recent patient participation group (PPG) feedback by introducing reserved elderly seating in the waiting area. We were also told that same day appointments had been introduced following PPG and wider patient survey feedback.

The practice was on the ground floor and had a ramped entrance for wheelchair users. Space was limited but there appeared to be space for a wheelchair user to turn. A disabled toilet was located near reception.

In reception, the practice had an automated patient check in system available in eighteen different languages. An electronic display board was located in reception to advise patients with a hearing impairment when they were being called for their appointment. We noted that there was reserved seating for elderly patients. The practice had access to interpreting support and staff had attended introduction to sign language courses. Protocols were in place to access British Sign Language interpreters.

Access to the service

Patients were offered a range of appointments from Monday to Friday 8:00am- 6:30pm depending on their needs, with extended hour's appointments on Monday (8.30pm). Any patient who arrived at the practice by 10am was seen by a GP that day. Home visits and telephone consultations were also available. Patients with an

emergency who called after 11am were offered an initial telephone assessment and then an appointment later that afternoon as necessary. Home visits were also offered for those that needed them.

The national GP Patient Survey 2013 reported that 61% of respondents found it easy to get through to the surgery by phone (better than the local CCG average). The practice website offered on-line bookings and on-line repeat prescription facilities. It also advised patients of public holidays in 2014 when the practice would be closed. The national GP Patient 2013 survey reported that 87% of patients surveyed said that the last appointment they got was convenient, which was better than the local CCG average.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was available at the practice and also on its website.

Concerns and complaints

The practice had a system in place for handling complaints and concerns which was advertised in reception and on the practice website. It also had a designated person to manage complaints. We were shown a complaints log, which required learning outcomes to be recorded for each complaint. However, not all the complaints we looked at had a corresponding learning outcome. We also noted that one complainant had been removed from the patient list without a full explanation or opportunity for redress. This was not in line with recognised guidance and contractual obligations. Opportunities to share learning from complaints amongst all staff were limited to six monthly staff meetings. We saw evidence that PPG complaints had been taken on board.

Patients told us that they had never had reason to complain but knew who to speak to if this was the case. We saw that the practice routinely responded to patient feedback left on the NHS Choices website and outlined how feedback would be used to improve the practice.

Are services well-led?

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

Our findings

Leadership and culture

Staff told us that they felt the practice was well led, that it had an open culture and that they felt supported in their roles. We asked one of the senior GPs about the practices' strategy and vision. They told us although there was not a strategy in place, the practice was "committed to providing responsive clinical care." They cited same day GP appointments and practice nurses' chronic disease management expertise as examples of this commitment.

Governance arrangements

We were told that each GP led on a specific area of governance such as safeguarding, infection prevention and control or information governance. However, these roles were not formally recorded so it was not clear how risks and performance in these areas were managed.

Systems to monitor and improve quality and improvement

The practice used Quality and Outcomes Framework (QOF) data to improve services and benchmark the practice with other practices in the borough. QOF performance highlighted for example that the practice's dementia care was in the top third for Newham practices. Records showed that QOF performance across a range of clinical areas was discussed at weekly clinical meetings.

Within the last twelve months, clinical audits had been carried out on two week cancer referrals and new cancer diagnoses but we noted that these were incomplete. There were no clear systems in place to specify how audit results would be shared or any subsequent service improvements monitored.

Patient experience and involvement

A Patient Participation Group (PPG) had been set up in 2010 and met approximately once every three months. Members

spoke positively about how the practice had sought and acted upon their views. This included, for example, introduction of reserved elderly seating in reception and same day GP appointments.

Staff engagement and involvement

The practice had introduced an action plan in response to the results of its 2013 patient survey. For example, we saw that GP telephone consultations had recently started in response to patient survey feedback.

We were told that staff meetings took place and that any staff member could contribute agenda items. However, we noted that these meetings were six monthly and not minuted. Shortly after our inspection, the practice advised us that the frequency of these meetings had been increased to every three months.

Learning and improvement

We were told that the practice had a learning culture. Annual staff appraisals took place and these including learning outcomes and targets. We noted that the practice conducted mortality reviews to ensure that patient deaths were reviewed and lessons learned to inform the service. We also saw evidence that the practice reviewed patient cancer diagnoses at its weekly clinical meetings to identify learning points such as whether the diagnoses could have been made earlier. However, there was no evidence that learning was formally shared with the wider staff team.

Identification and management of risk

We noted an absence of risk assessment systems regarding infection prevention and control and pre-employment checks. This meant that there was a risk that significant issues in these areas, affecting the delivery of safe and effective care were not being identified or adequately managed. There were also infrequent opportunities as a staff team to identify and manage risk, by way of significant events analyses.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice was responsive to the needs of older people. The practice was on one floor and we saw that it had a ramped entrance for wheelchair users. Space was limited

but there appeared to be space for a wheelchair user to turn. Older patients spoke positively about how care was delivered. We noted that there was reserved seating for elderly patients in reception. Home visits were offered and we noted that patients over 75 had a named GP.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

GP's participated in multidisciplinary meetings where patients' conditions were reviewed. Patients with long term conditions spoke positively about how the practice

provided sufficient information to be able to make informed decisions about managing their condition. Practice nurses and some GPs had attended nationally recognised specialist training in chronic disease management.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice was responsive to the needs of mothers, babies, children and young people. For example, before our inspection, we noted that Newham has the highest birth rate in England and on inspection, we saw that the practice provided weekly antenatal clinics to pre-expectant mothers. GPs had attended advanced child protection

training and we saw evidence of multidisciplinary meetings with other clinicians such as health visitors. Before our inspection, we also noted that the proportion of people below 40 years was above the England average. During the inspection, we noted that the practice ran a weekly drop in sexual health clinic to address the sexual health needs of its young population.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice was responsive to the needs of working aged people and those recently retired. Patients were offered a mixture of appointments at the practice from Monday to Friday 8:00am- 6:30pm with extended hours appointments

on Monday until 8.30pm. This meant that there was a choice of appointment times before and after work. We noted that any patient who arrived at the practice by 10am was seen by a GP that day. Telephone consultations were available and appointments and repeat prescriptions could be made online.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice was responsive to the needs people in vulnerable circumstances. We were told that sex workers who attended the practice's sexual health drop in clinic were offered referral to local substance misuse agencies for

specialist support. The practice also provided annual health checks for patients with a learning disability and systems were in place to provide British Sign Language (BSL) interpreters. Practice staff had also attended introductory BSL courses.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice was responsive to the needs of people experiencing poor mental health. The practice hosted a weekly mental health community nurse pilot project, which enabled outpatients to be treated in familiar community settings rather than at a local hospital. We also noted that

multidisciplinary meetings included community mental health teams. Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA 2005) and their obligations to patients who lacked capacity. Records showed that practice nurses were scheduled to attend MCA 2005 training in September 2014.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control</p> <p>Regulation 12, Health & Social Care Act 2008 (Regulated Activities) Regulations 2010</p> <p>Cleanliness and Infection Control</p> <p>How the regulation was not being met:</p> <p>People who use services and others were not protected against the identifiable risk of acquiring a health care associated infection:</p> <p>Infection prevention and control audits had not taken place.</p> <p>The provider was not using risk assessed cleaning schedules.</p> <p>The provider was unable to evidence that a Legionella risk assessment had taken place.</p> <p>12 (2) (a)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers</p> <p>Regulation 21, Health & Social Care Act 2008 (Regulated Activities) Regulations 2010</p> <p>Requirements relating to workers</p> <p>How the regulation was not being met:</p>

This section is primarily information for the provider

Compliance actions

The provider failed to ensure that criminal record certificates or other such information as is appropriate was available in respect of persons employed for the purpose of carrying on a Regulated Activity:

The provider was unable to evidence that its decision not to carry out Disclosure and Barring service (DBS) checks for administrative staff had been risk assessed.

Regulation 21(a)(i) (b)