XX Place Health Centre

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at XX Place Health Centre 19 October 2017. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example the practice held a variety of multi-disciplinary team meetings (MDTS) with organisations such as Community Mental Health Teams (CMHTs), Community Palliative team and external consultants.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

Summary of findings

- The practice was part of the Well Programme along with the Bromley by Bow Partnership where they looked at patient care in a holistic way.
- The practice ran a social prescribing programme (with weekly session in surgery) to address wider holistic health needs such as employability, welfare benefits advice, addressing isolation.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation.
- Information about safety was highly valued and was used to promote learning and improvement.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Our findings at inspection showed that there were systems to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients.
- Data showed that the practice was performing highly when compared to practices nationally. For example, the percentage of patients with atrial fibrillation in whom stroke risk has been assessed in the preceding 12 months was 100% compared to the CCG and national average of 97%.
- The practice used innovative and proactive methods to improve patient outcomes and had empowered patients and helped them self-manage their health in partnership with the practice through technology such as a free Health Touch 'app' for patients with high blood pressure and the DIY Health educational programme for parents of children under the age of five. Which supported parents with managing self-limiting childhood problems, the group learning sessions aimed to empower the parents with knowledge, confidence and skills to manage minor ailments at home.

Summary of findings

- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 85% the same as the CCG average and comparable to the national average of 80%.
- The practice ensured that patients with complex needs, including those with life-limiting progressive conditions, were supported to receive coordinated care in innovative and efficient ways.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for almost all aspects of care.
- 91% of patients said the last GP they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 80% and the national average of 86%.
- Feedback from patients about their care and treatment was consistently positive.
- We observed a strong patient-centred culture and staff were fully committed to working in partnership with patients.
- The practice held an annual tea party to raise money for a local hospice and encourage patient feedback using the Friends and Family test. The practice online services was driven and organised by the practices administration team.
- We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on.
- Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning services that met patients' needs.
- The 2017 National patient survey results found that 52% of patients who responded said they could get through easily to the practice by phone compared to the CCG average of 68% and the national average of 71%.
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice, as part of Bromley by Bow Health Partnership, had established the Well

Summary of findings

Programme and the community-facing element the Well Community with enabled solutions to health issues to be co-created by primary care staff and patients. As part of this initiative the practice had started the social group 'Chatter Natter' for older and potentially isolated people to meet and have some refreshments and friendly conversation.

- There are innovative approaches to providing integrated patient-centred care. All patient facing staff were called patient assistants this helped to in bed the practice ethos of being patient focused.
- The individual needs and preferences of people with a life-limiting condition, including patients with a condition other than cancer and patients living with dementia, were central to their care and treatment. Care delivered was flexible and provided choice.
- The practice looked after patients in two Care Homes. A team of GPs, an Advanced Nurse Practitioner (ANP), nurses and healthcare assistants visited weekly and they held quarterly review and co-ordination meetings with care home staff (An Advanced Nurse Practitioner (ANP) focuses on the primary care of adults, the main roles of ANPs focus on preventive care involving health promotion and disease prevention as well as the management of patients with acute and chronic health issues)
- Patients can access appointments and services in a way and at a time that suits them, either face to face, via the telephone or online.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.

Summary of findings

- There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff told us that they felt empowered to make suggestions and recommendations for the practice.
- The practice gathered feedback from patients using new technology, and it had a very engaged patient participation group which influenced practice development. For example the patient participation group had produced a practice newsletter with the support of the practice team.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice held a tea party with their local hospice where they gave health education advice on end of life and palliative care with patients in the practice waiting room.
- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice looked after patients in two Care Homes. A team of GPs, ANP, nurses and healthcare assistants visited weekly. They held quarterly reviews and co-ordination meetings with care home staff.
- The practice 'Chatter Natter group' was run by their Patient Assistants and supported older patients, who were socially isolated.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 85% which was the same as the CCG average and comparable to the national average of 80%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their

Summary of findings

health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice offered NHS Health checks to all patients within the age group of 40 to 74 every 5 years, any high risk patients would be seen annually.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were average for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, the team met regularly with the Health visitors and midwives at the surgery on a weekly basis for their antenatal clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- The clinical commissioning group administrator for Safeguarding & Looked After Children notified the lead safeguarding GP on any addition or removal of children from the Child on Protection plan and children in need register these children were discussed in their quarterly over five's safeguarding clinical meetings and appropriate action was taken.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

Summary of findings

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours Mondays and Tuesdays.
- The practice referred adults via social prescribing to welfare benefits advice, employment and training advice, and opportunities to volunteer.
- The practice helped to promote healthy lifestyles through referral to Fit for Life and promoted uptake of cancer screening services (Fit for Life was designed to help patients with healthy eating programmes, physical activity, weight management and gave motivational support to help patients live a healthier life).
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. Patients also had access to e-consultation through the practice website and patients with high blood pressure were able to us the Health Touch App that allowed patients to home-monitor their health, submit readings through an 'app' and communicate with the practice's clinical team.
- The practice hosted additional services for patients including psychology, and health advocacy.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice referred patients to their in house Social prescriber. This was a CCG wide initiative helped the practice and the borough care for patients in a more holistic way by enabling healthcare professionals to refer to a single point of access for a patient's social, financial and housing needs and so much more.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice had links with and referred patients to IRIS Domestic Violence project and held in house training sessions.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations, for example they held fortnightly citizens advice bureau sessions at the practice.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice carried out advance care planning for patients living with dementia.
- 90% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the CCG average of 91% and the national average of 84%.
- The practice held multi-disciplinary team meetings (MDTS) with Community Mental Health Teams (CMHTs), every two months for patients with mental health issues such as dementia.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. The practice referred patients to their in-house social prescriber.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 95% compared to the CCG average of 90% and the CCG average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

- All the practices patients were followed up or reviewed after A&E as part of their post discharge protocol and patients were seen in the surgery if needed.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with local and national averages. 391 survey forms were distributed and 88 were returned. This represented a 23% completion rate and 1% of the practice list.

- 70% of patients described the overall experience of this GP practice as good compared with the CCG average of 78% and the national average of 85%.
- 51% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 60% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 72% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 17 comment cards, 13 of which were all positive about the standard of care received four of the card mentioned difficulty in getting through on the phone.

We spoke with 11 patients during the inspection. All the patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. They did however feel that the telephone system made it difficult to get through on the phone to access appointments.

The Friends and family test showed the 81% of patients asked would recommend the practice to their friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Ensure improvements are made to address patient access to appointments as identified in the patient survey.

Outstanding practice

- The practice introduced a Chatter Natter group' run by their Patient Assistants, supporting older patients, and a soon to be introduced Book Club.
- Patients could access the "Health Touch" App for patients with high blood pressure to enable them to manage their condition better in their own homes.
- The practice were part of the DIY Health educational programme for parents of children under the age of five. Which supported parents with managing self-limiting childhood problems.

XX Place Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser and an Expert by Experience.

Background to XX Place Health Centre

XX Place Health Centre is located on the ground and first floors of the Alderney Building on the site of Mile End Hospital in London E1 and is part of Tower Hamlets clinical commissioning group (CCG). The building is owned and maintained by Bart's Health NHS Trust. XX Place Health Centre is part of the Bromley by Bow Health Partnership which also includes the Bromley by Bow Health Centre and St Andrews Health Centre and Walk in Centre. They hold a General Medical Services (GMS) contract jointly with Bromley by Bow Health Centre (a GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities).These two practices sites share an EMIS system and data set, XX Place Health Centres patient list size is currently 8,777.

The practice is registered with the Care Quality Commission to carry on the regulated activities of treatment of disease, disorder or injury, diagnostic and screening procedures, maternity and midwifery services, surgical procedures and family planning.

The practices opening hours are;

Monday and Tuesday 8am to 8pm (Extended hours)

Wednesday to Friday 8am to 6.30pm

The phone lines are closed between 1pm to 2pm Monday to Friday. The doors remain open during this time and reception is staffed throughout the day. There is a duty doctor available 8am to 6.30pm.

The phone lines are transferred to the Tower Hamlets Out of hours' service when the phones lines are closed.

They also offer appointments at four local hubs, appointments at the hubs are available Monday – Friday from 18:30pm – 8pm and 8am – 8pm on Saturday and Sunday.

The staff team at the practice included two partners one Nurse Director and one GP (both female) working seven clinical sessions each per week, seven salaried GPs (three female and four male) providing 36.75 sessions per week. Four practice nurses (female), an Advanced Nurse Practitioner and three health care assistants (female) covering 224.5 hours per week. There is a practice manager and a practice manager assistant, seven administrative staff and 10 patient assistants.

The life expectancy of male patients is 78 years, which is comparable than the national average of 79 years. The female life expectancy at the practice was 82 years, which is comparable national average of 83 years. Information published by Public Health England rates the level of deprivation within the practice population group as three on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest. People living in more deprived areas tend to have greater need for health services. The practice catchment area has a large Bangladeshi population with 40% of its patients listed as Asian or Asian British. The practice has a much larger than average proportion of young adults on its patient list, particularly in the age range 20-34.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

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 19 October 2017 During our visit we:

- Spoke with a range of staff (GPs, practice manager, nurse and administration staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia)

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of 10 documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example when a miscommunication between the practice and a local pharmacy resulted in an incorrect prescription being sent to the wrong pharmacy and some confidential information disclosed. This was corrected quickly and no medicines were dispensed. This was discussed as a significant event and guidelines were strengthened by ensuring staff checked details before giving information out over the phone and reinforcing the protocols for information governance and confidentiality.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the sample of two documented examples we reviewed we found that the practice held child safeguarding meetings quarterly and when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three, nurses to level three and two and other non-clinical staff to level one.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure

prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The most recent published Quality Outcome Framework (QOF) results were 98% of the total number of points available compared with the clinical commissioning group (CCG) and national average of 95%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). The overall exception reporting rate for the practice was 6% compared with a national average of 10% (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

- Performance for diabetes related indicators was similar to the CCG and the national average. For example 85% of patients on the diabetes registers last cholesterol reading was 5mmol/l or less, which was the same as the CCG average and comparable to the national average of 80%. The exception reporting rate was 5%, which was comparable to the CCG and national average of 6% and 13% respectively.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 87%, which was comparable to the CCG average of 88% and the national average of 83%. Exception reporting was 2% which was comparable to the CCG average of 3% and the national average of 4%.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 92% compared to the CCG average of 89% and the national average 90%. Exception reporting was 11% comparable to the CCG average of 6% and the national average of 12%.
- Performance for mental health related indicators was comparable to the CCG and national average. For example, 91% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive agreed care plan documented in their record in the preceding 12 months compared to the CCG average of 81% and a national average of 89%. This meant that the exception reporting rate was 7%, which was the same as the CCG average and comparable with the national average of 13%.
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 97% compared to the CCG average of 96% and the national average of 95%. The exception report for both the practice and CCG were in line with national averages at less than 1%.

There was evidence of quality improvement including clinical audit:

- There had been nine clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example; the practice undertook a two cycle end of life audit, the purpose of this was to increase the percentage of patients on the palliative care register at the time of death in order to provide improved care to patients and their carers. They reviewed the number of patients who had died in the last two years and looked at whether they were on the palliative register and had they died in their preferred place, the percentage on the first cycle was 24%. Actions taken after the first cycle audit included an increased effort to ensure the clinical team were identifying patients who were coming to the end of their lives and putting them on the palliative care register and to ensure had been made aware of the end

Good

Are services effective?

(for example, treatment is effective)

of life pathways and services e.g. informing Out of Hours about patients dying at home and the need to provide continuity of care to patients and carers. The second cycle audit the following year showed that the percentage on the palliative register had risen to 54%.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the nurses reviewing patients with long-term conditions go for regular updates on subjects such as cytology.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

Good

Are services effective?

(for example, treatment is effective)

- Last year the Chatter Natter group and one of the practices patient assistants put a successful bid in for "Change for Life" "Can do community" projects, which prioritised the improvement of mental health and increasing physical activity in the community.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 79%, which was comparable with the CCG average of 78% and the national average of 81%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 88% to 95% (national average 90%) and five year olds from 80% to 95% (88% to 94% nationally).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 17 patient Care Quality Commission comment cards we received were positive about the standard of care received; four mentioned it was sometimes difficult to access appointments. This is in line with the results of the NHS Friends and Family Test and other feedback received about the practice.

We spoke with 11 patients including three members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required, they did however mention problems with telephone access.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 86%.
- 89% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 85%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and the national average of 86%.
- 86% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 83% and the national average of 91%.
- 82% of patients said the nurse gave them enough time compared with the CCG average of 83% and the national average of 92%.
- 93% of patients said they had confidence and trust in the last nurse they saw which was the same as the CCG average and comparable to the national average of 95%.
- 79% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 91%.
- 72% of patients said they found the receptionists at the practice helpful compared with the CCG average of 82% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 91% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 80% and the national average of 86%.
- 83% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 82%.

Good

Are services caring?

- 88% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 90%.
- 79% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation 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. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 212 patients as carers (2.4% of the practice list). Written information was available to direct carers to the various avenues of support available to them and the practices website signposted them a carers support site.

Staff told us that if families had experienced bereavement, their usual GP contacted them and sent them a sympathy card. There was also a bereavement pack available which sign posted family's to advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice offered extended opening hours Mondays and Tuesdays from 6:30pm to 8pm, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments. There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice has implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice held a tea party with their local hospice where they gave health education advice on end of life and palliative care with patients in the practice waiting room.
- The practice looked after patients in two Care Homes. A team of GPs, ANP, nurses and HCAs visited weekly. They held quarterly reviews and co-ordination meetings with Care Home staff.
- The practice 'Chatter Natter group' was run by their Patient Assistants and supported older patients, who were socially isolated.
- The practice were part of the DIY Health educational programme for parents of children under the age of five. Which supported parents with managing self-limiting childhood problems. These group learning sessions aimed to empower the parents with knowledge, confidence and skills to manage minor ailments at home.
- The practice helped patients to self-manage their high blood pressure with their "Health Touch" app that allowed patients to home-monitor their health, submit readings through an 'app' and communicate with the practice's clinical team, this also reduced the need for patients to book appointments.
- The practice are part of the Well Programme initiative started by the Bromley by Bow Health Partnership its aim was to develop a new model of primary care, with people and community at its heart. It is a model in which patient care is not only delivered by healthcare professionals but by a holistic team which could include a nurse, a trainer and a community worker where health is inseparable from social care and public health.

Access to the service

Monday and Tuesday 8am to 8pm (including extended hours) and Wednesday to Friday 8am to 6.30pm. The phone lines are closed between 1pm to 2pm Monday to Friday. The doors remain open during this time and reception is staffed throughout the day. There is a duty doctor available 8-6.30pm. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for patients that needed them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 74% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) and national averages of 76%.
- 52% of patients who responded said they could get through easily to the practice by phone compared to the CCG average of 68% and national average of 71%.
- 68% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared to the CCG average of - 79% and national average of - 84%.
- 62% of patients who responded said their last appointment was convenient compared to the CCG average of 74% and national average of 81%.
- 51% of patients who responded described their experience of making an appointment as good compared to the CCG average of 67% and national average of 73%.
- 25% of patients who responded said they don't normally have to wait too long to be seen compared to the CCG average of 47% and national average of 58%.

The practice were aware that patients were dissatisfied with the experience of booking an appointment. As a result they recently trialled a telephone triage system which showed that they increased capacity by another session of GP appointments each week. They had also delegated some administration tasks to Patients Assistants and Healthcare Assistant's which allowed them to increase GP appointments by 12 per week.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

For home visits patients had to call in the morning and speak to the on call GP who would triage the calls to make an informed decision on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a complaints leaflet and poster in the waiting area.

We looked at 23 complaints received in the last 12 months and found that they were satisfactorily handled, dealt with in a timely way, with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, when a patients repeat prescription request was rejected. The patient was not informed or given a reason why and had to request it again. It was explained to the patient that a review was required as the patient had not had that prescription for a while. This was discussed at a practice meeting and the procedure was amended so that if prescription was rejected it would be added to the patient notes and the patient informed.

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.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- The practice was very active within the Tower Hamlets CCG.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas for example, one of the GP partners was the adult safeguarding lead and the practice nurse was the infection control lead.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice had a variety of risk assessments for fire, health and safety and Legionella and all actions identified had been dealt with.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality, patient centred and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of 10 documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular monthly team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted that management team away days were held every six months. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Good

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example; the PPG had produced a practice newsletter with the support of the practice team which enabled the practice to let patients know what was happening in the practice and also a way for them to canvass their views.
- the NHS Friends and Family test, complaints and compliments received.
- staff through staff meetings, appraisals and discussion. 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 to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example;

- The practice, as part of Bromley by Bow Health Partnership, had established the Well Programme managed by a dedicated team which facilitated the development of new models of primary care with people and the community at its heart. The practice told us the programme is about wellness and not just managing illness and supported patients to manage their own health.
- The practice was an active participant of the Social prescribing programme and held weekly sessions in the surgery.
- The practice helped patients to self-manage their high blood pressure with their “Health Touch” app that allowed patients to home-monitor their health, submit readings through an ‘app’ and communicate with the practice’s clinical team this also reduced the need for patients to book appointments.
- The practice ‘Chatter Natter group’ was run by their Patient Assistants and supported older patients, who were socially isolated.