The Globe Town Surgery

Quality Report

82 – 86 Roman Road
London
E2 0PJ
Tel: 0208 980 3023
Website: www.globetown.org

Date of inspection visit: 6 November 2017
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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

This practice is rated as Good overall. (Previous inspection November 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at The Globe Town Surgery on 6 November 2017. The practice was previously inspected in November 2014. All key questions were rated as good and this inspection was to ensure that the practice were maintaining standards. At that inspection there were a small number of areas identified that the provider needed to improve and we found these had been addressed.

At this inspection we found:

- 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.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen, although we found the arrangements for the storage and access to drugs and equipment for managing medical emergencies, across both the main site and branch surgery needed to be reviewed as equipment was not clearly labelled and the right equipment was not easily identifiable in an emergency.
- When incidents did happen, the practice learned from them and improved their processes.

Summary of findings

- Patients found the appointment system easy to use but feedback from the GP survey suggested that they were not always able to access care when they needed it. Patients could also make appointments or consult a GP online.

- The practice proactively sought feedback from staff and patients, which it acted on.
  - There was a strong focus on continuous learning and improvement at all levels of the organisation, although not all staff had received an annual appraisal.

- There was a clear leadership structure and staff felt supported by management.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- We found the practice had not clearly displayed its previous inspection report or ratings but they confirmed they would do that without delay.

The areas where the provider **should** make improvements are:

- Review the arrangements for the storage and access to drugs and equipment for managing medical emergencies, across both the main site and branch surgery.
- Review availability of equipment to manage medical emergencies taking into account guidelines issued by the Resuscitation Council (UK).
- Review the system for staff appraisal so that all staff have an opportunity for annual appraisal.
- Review the call / recall arrangements for cervical screening to ensure responsibility for this is clear
- Review the current low number of carers identified

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

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
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

The Globe Town Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team also included a GP specialist adviser.

Background to The Globe Town Surgery

The Globe Town Surgery operates from 82 – 86 Roman Road, London, E2 0PJ. The practice provides NHS primary medical services through a Primary Medical Services contract to just over 14,000 patients in the Tower Hamlets Area. Approximately 6,000 of those patients are students. The practice is part of the Tower Hamlets Clinical Commissioning Group (CCG) and is part of a network of five practices in the CCG creating 'The One Network'.

The practice also has a branch surgery at Queen Mary University providing student health services. It comprises one waiting room, one reception area, a treatment room and a consultation room. We visited this service as part of our inspection.

The practice has one male GP (and one male locum GP who worked regularly at the practice), four part time female GPs (and two female locum GPs who worked regularly at the practice), who provided a combined total of 40 sessions. There were two practice nurses, two healthcare assistants, a part time phlebotomist, a practice manager, reception manager and an administrative team of 12 part time and two full time staff. The practice is a training practice. At the time of inspection there was one GP registrar placement.

The practice has level access via a ramp from the pavement and consultations are all provided on the ground floor level. There are good bus and rail links close to the practice and some parking spaces for disabled people close by. It has a waiting room in front of the main reception desk.

It has a high proportion of patients who are non-English speaking or whose first language is not English and a significantly higher than average younger population but a lower than average older population. The average age of patients was 27.7 years and the practice has six times the national average of 20-24 year olds due to being the health care provider for students at the Queen Mary University.

The practice is in an area with a high deprivation weighting. The Indices of Multiple Deprivation score is two. The lower the Indices of Multiple Deprivation decile, the more deprived an area is.

The practice is registered with the CQC to provide the regulated activities Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder or injury.

The practice has a website which provides a range of information about the practice and services provided. It can be accessed here www.globetown.org.

The practice reception and surgery opening hours are:

Monday to Wednesday: 8.45am – 6pm

Thursday: 8.45am – 1pm – closed in the afternoon

Friday: 8.45am to 1pm and 2pm to 6pm

Saturday and Sunday: Closed

Appointments are from 9am and the last face to face appointment is available at 5:50pm or 6:10pm for telephone consultations. Appointments are available throughout the day.

Detailed findings

Extended appointments can be made on any day when the practice is open. If the practice is closed there is a number patients can call to obtain the Out of Hours service contact details. This is also on the practice leaflet and website.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out (DBS
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.
- There were systems for safely managing healthcare waste although we found that cleaning equipment was not appropriately stored or available in line with national guidance.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Although we found that the arrangements for the storage and access to drugs and equipment for managing medical emergencies, across both the main site and branch surgery needed to be reviewed. The emergency drugs and equipment were stored in drawers within plastic trolleys which were not well labelled and the right equipment was not easily identifiable in an emergency which could delay action. There were pads for use with the Automated External Defibrillator (AED) suitable for use on children from the age of eight years but no specific paediatric pads. The practice had carried out a risk assessment and consulted their resuscitation advisor and determined that paediatric pads were not required.
- There was no AED at the branch surgery. Although we were told three were available within the university, no risk assessment had been carried out to determine if that was a reliable alternative. The emergency procedure for the branch surgery was to call the university security and ask for the defibrillator. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

Good

Are services safe?

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- The practice also had a daily duty prescribing doctor to ensure repeat prescribing was well managed.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following a delay in the diagnosis and referral of a patient, the practice identified three areas for improvement: the necessity of reading a longer period of prior consultations, ensuring that where appropriate, an advocate was booked to support the consultation and the importance for GPs in sifting multiple problems / symptoms during a consultation.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Prescribing Unit (01/07/2015 to 30/06/2016) for the average for the practice was 0.27% which was better than the national average of 0.98%.
- The percentage of antibiotic items prescribed that are Cephalosporins or Quinolones (01/07/2015 to 30/06/2016) was 8% compared to the national average of 5%.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had commenced online consultations and encouraged self-care by providing access to a range of information and support from use of social prescribing.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

For example:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had offered 179 patients a health check. 175 of these checks had been carried out.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Working proactively with the local Community Health Services (including a community mental health nurse for the elderly and a consultant geriatrician), holding regular multi-disciplinary team meetings to inform care planning, a fast response access service and falls clinic.
- Use of social prescribing, for example referral to befriending services or day centres.

People with long-term conditions:

For example:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice has a rotation of allied health professionals who ran sessions at the practice in order to improve convenience for patients as well as attendance. These include the Cardiovascular Disease nurse, the Diabetic Specialist Nurse (for insulin initiation) and the Diabetic Dietician.
- GPs who had concerns regarding a patient with certain long term conditions, for example Diabetes, could take cases for discussion to the Diabetes network based Multi-Disciplinary Team meeting which was consultant and specialist nurse led.

Families, children and young people:

For example:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above for five year olds but very slightly under 90% for vaccinations up to two years. Parents who refused vaccinations were contacted by the lead GP for children and safeguarding, to address the

concerns of the parent and provide evidence based information to promote vaccinations. This proactive approach had helped attendance and keep vaccination rates up.

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

For example:

- The practice's uptake for cervical screening was 65%, which was below the 80% coverage target for the national screening programme. The practice were aware of this and although enabled book on the day appointments and opportunistic screening, they did not have extended hours appointments at the practice for working women but appointments could be made at a hub practice. Patients whose first language is not English may not have understood invite letters and the practice were aware of potential cultural barriers to examination. Although the practice had a call and re-call system in place, it was not clear who was responsible for this.The practice manager told us they were actively monitoring this.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

For example:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Patients were visited every two weeks prior to their death.
- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. There is a practice in Tower Hamlets which has a contract to provide primary medical services for homeless people. The practice refers homeless people to that practice, unless they are newly homeless practice patients.
- A social prescriber held sessions in the practice and could direct patient to support groups and projects in the borough which could help improve mental and physical health. For example, food banks, charities, support groups, exercise projects and networking groups.
- Providing advocates for people with language barriers.

People experiencing poor mental health (including people with dementia):

For example:

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  The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 90%; CCG (no data); national 89%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 94%; CCG (no data)%; national 95%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

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) average of 95% and national average of 95%. The overall exception reporting rate was 3% compared with a national average of 6%. (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.)

Good

Are services effective?

(for example, treatment is effective)

- The practice used information about care and treatment to make improvements. For example, the practice had not quite met the 90% target for childhood immunisations up to age two. They contacted parents and GPs had one to one discussions with parents to encourage uptake.
- Additionally, following an end of life care audit, the practice identified the need to improve the provision of information to the out of hours service about end of life care needs. The practice had not at the time of inspection carried out a second cycle of this audit.
- The practice was actively involved in quality improvement activity. The practice had a continuous programme of clinical audit. For example, this included audit of cardiology referrals, dermatology referrals, antibiotic prescribing, end of life care. In relation to antibiotic prescribing, the practice had reduced their broad spectrum antibiotic prescribing since the previous audit. This was following an antibiotic update. There was still scope for improvement in relation to antibiotic prescribing, particularly in relation to suspected urinary tract infections (UTIs) / pyelonephritis. The practice had reviewed in detail the prescribing that was not in line with national guidelines and their local formulary and had suggested improvements. Where appropriate, clinicians took part in local and national improvement initiatives. The practice was part of the 'One Network' group of practices and participated in a local Network Incentive Scheme to improve network targets in treating patients. These were over and above those set nationally. This enabled benchmarking, peer review and improved performance. For example patients with long term conditions such as diabetes or hypertension, or those with mental health problems.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with
- The induction process for healthcare assistants (HCA) included the requirements of the Care Certificate, although one HCA had not completed any equality and diversity training. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.

Good

Are services effective?

(for example, treatment is effective)

- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- 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.
- All of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Three hundred and eighty six surveys were sent out and 64 were returned. This represented about 0.4% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients who responded 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%.
- 82% of patients who responded said the GP gave them enough time; CCG - 80%; national average - 86%.
- 92% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 93%; national average - 95%.
- 76% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 79%; national average - 86%.
- 76% of patients who responded said the nurse was good at listening to them; (CCG) - 83%; national average - 91%.
- 85% of patients who responded said the nurse gave them enough time; CCG - 83%; national average - 92%.
- 86% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 93%; national average - 97%.
- 79% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 81%; national average - 91%.
- 78% of patients who responded said they found the receptionists at the practice helpful; CCG - 82%; national average - 87%.

The practice were aware of the feedback in relation to patients experiences and were supporting the team to improve. For example, through training and supervision.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- 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.

The practice proactively identified patients who were carers. Through information provided by patients at registration, multi-disciplinary integrated care team meetings, opportunistically, for example when attending appointments. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 106 patients as carers. Although this was less than 1% of the practice list, the practice had over 4,000 students registered and the average age of the practice population was 27.7. The practice advised us that the lower age range accounted

Good

Are services caring?

for them not identifying at least 1% as carers. The practice website had a dedicated page providing information for carers, assess carer needs and support carers to access local services, such as the carers centre, providing flu vaccination.

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice website had a page dedicated to information which patients may find helpful following a bereavement, although this did not include any services the practice provided.

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:

- 78% 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%.
- 85% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 76%; national average - 82%.
- 74% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 82%; national average - 90%.
- 67% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 77%; national average - 85%.

The practice were aware of the feedback in relation to patients experiences and were supporting the team to improve. For example, through training, supervision and appraisal.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998. The practice was registered as a data controller on the Data Protection Register to 12 December 2017.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. (For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, online consultation and advice services for common ailments, including through Pharmacy First).
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were adequate for the services delivered but the practice has recently agreed plans for a move to a new premises to enable them to provide more services.
- The practice made reasonable adjustments when patients found it hard to access services. For example, hearing loop in reception, home visits for those who were housebound, ramp from pavement into the practice, wheelchair accessible toilet, advocacy and interpreter services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

For example:

- 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.
- Patients with complex care management had care plans

People with long-term conditions:

For example:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs and to minimise non- attendance.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- There was an anticoagulation clinic on site.
- There was also a local Network Incentive Scheme to improve practice targets and the outcomes of patients with long term conditions

Families, children and young people:

For example:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children on the child protection register, children and young people who had a high number of accident and emergency (A&E) attendances, weight management services and Pharmacy First. Pharmacy First pharmacists in Tower Hamlets could give advice and treatment on a range of minor health problems including short term drug treatments. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

For example:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments were available at another practice within the hub.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

(for example, to feedback?)

For example:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People who were homeless were referred to a practice in Tower Hamlets who had a contract and the expertise to treat homeless patients, although the practice would treat their newly homeless patients.
- Staff had training on the PREVENT guidance and strategy. The Prevent duty aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves.

People experiencing poor mental health (including people with dementia):

For example:

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated bi-monthly mental health and dementia clinics. Also the student mental health service. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Frequently used care navigators and social prescribing to help support patients.
- Held a fortnightly meeting with the specialist primary care mental health nurse and community mental health nurse for the elderly.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. Three hundred and eighty six surveys were sent out and 64 were returned. This represented about 0.4% of the practice population.

- 68% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 54% of patients who responded said they could get through easily to the practice by phone; CCG – 68%; national average - 71%.
- 72% 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; CCG - 79%; national average - 84%.
- 62% of patients who responded said their last appointment was convenient; CCG - 74%; national average - 81%.
- 59% of patients who responded described their experience of making an appointment as good; CCG - 67%; national average - 73%.
- 44% of patients who responded said they don't normally have to wait too long to be seen; CCG - 47%; national average - 58%.

The practice were aware of their scores for the above areas but also used feedback from their Friends and Families Test results which was always reviewed in meetings and the practice felt was more reflective. The practice had made a number of changes to improve access. For example, had increased the number of administrative staff at peak times, provided a self check-in option, enabled online access and Web GP consultations, increased the number of lines into the practice. They had a daily duty doctor and a different doctor who dealt with repeat prescribing daily. This had resulted in a reduction in the number of patients not attending booked appointments and consequently increased availability of appointments. Overall feedback to the practice suggested these measures were improving access. In relation to prescribing, the practice told us this enabled a safer and more effective review of repeat requests.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Fourteen complaints were received in the last year. We reviewed five complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, following a consultation where a chaperone was not offered, the practice reminded staff of the need to make patients aware of this and ensured the chaperone policy and posters were prominently displayed.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- 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.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The practice always provided an explanation to support their clinical decision and that patients had a choice about treatment and whether to follow a care plan. Where necessary an apology was always provided. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations, although we found that not all staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Are services well-led?

Good

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- We found that the practice had not conspicuously displayed the last Care Quality Commission inspection report or ratings on its website but told us they would do this without delay.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, this ranged from the need to improve the premises and access options to the service, to looking out to the community and holding health educational events in the local mosques. Have the ability to pre-book an advocate for an appointment. Provide information about the PPG and some minutes of meetings on the provider website.
- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example, a move to new premises to improve the range of services provided and ability for more allied professionals to be located on site, learning from

Are services well-led?

Good

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significant events and planning subsequent educational events. The partners were also planning on introducing a management psychologist to help develop the leadership team.

- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.