MEEBBB Health CIC (St Pauls Way Medical Centre)

Quality Report

99 St Paul's Way
London
E3 4AJ
Tel: 020 7538 0833
www.stpaulswaymedicalcentre@nhs.uk

Date of inspection visit: 26 November 2014
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

MEEBBB (Mile End East and Bromley by Bow) Health CIC (St Pauls Way Medical Centre) provides GP primary medical services to approximately 10,500 patients living in the London Borough of Tower Hamlets. The practice is a Community Interest Company run by representatives from four other local GP practices.

We carried out an announced comprehensive inspection on 26 November 2014. The inspection took place over one day and was undertaken by a lead inspector, a second CQC inspector and two GP Specialist Advisors. We looked at care records, spoke with patients, members of the patient participation group (PPG) and staff including the management team.

Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing effective, responsive services and for being well led. It was rated Good for providing safe and caring services.

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

- The service is safe. Systems including incident reporting protocols, safeguarding measures and infection control procedures were in place to keep patients safe.
- The service is effective. Staff were appropriately qualified to deliver effective care and treatment in line with NICE guidance and they shared best practice with external consultants and other GP practices.
- The practice is caring. Patients said that staff were welcoming, caring and treated them with dignity and respect and the GP's involved them in decisions about their treatment and care.
- The practice is responsive to people's needs. The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

Summary of findings

- The practice is well-led. The practice had a clear vision and strategy to go beyond clinical outcomes and support patients in a holistic sense taking into account and addressing wider issues such as housing, education and other social issues and health determinants.

All the population groups including older people; people with long term conditions; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health received care that was safe, effective, caring, responsive and well-led.

We saw several areas of outstanding practice including:

- Improvements in care for patients who use services are made as a result of ongoing monitoring and clinical audit programme. Completed audit cycles had been undertaken and audits had been shared and extended to the GP practices within the network. The practice had also engaged with external consultants in relation to audits undertaken.
- A systematic approach is taken to working with others in the health and social care economy to improve care outcomes and tackle inequalities. The practice participates in a Social Prescribing project jointly funded by funded by MEEBBB Health CIC and Tower Hamlets CCG in which they refer patients to wider support services, activities and programmes within the borough. The practice regularly engages with Public Health England and the community drug therapies team and provides weekly Benefits Advisor sessions for patients. The practice undertakes a number of health promotion activities both in house and out in the community to enable patients and members of the public to increase control over, and to improve, their health. The practice promoted healthy eating by holding workshops every six months at a local café and signposted patients to various services according to which health changes they want to make.
- The practice had analysed the Joint Strategic Needs Assessment data and the priorities of the Clinical Commissioning Group (CCG) and local authority in the planning of its services to meet the needs of the local population. These included extended hours for appointments, diabetes clinics and substance misuse services. The practice opening hours were 8am – 8pm Monday to Friday and 9am -5pm on Saturdays.
- There is a strong commitment to developing skills, competence and knowledge of staff through an in practice weekly mentoring an annual learning programme. The practice allocated protected time for clinicians each week for mentoring. Mentoring sessions included discussions on referrals, results and prescribing and provided an opportunity for personal development and career progression.
- There are consistently high levels of constructive staff engagement and a high level of staff satisfaction. Staff are proud of the practice and contribute to the practice's vision to go beyond clinical outcomes and support patients in a holistic way.

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

Importantly, the provider should:

- Carry out a fire risk assessment to ensure patients and staff are protected from the risks associated with fire in the premises.

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.

Procedures were in place to ensure incidents were reported, analysed and learning shared. Safety alerts received from the NHS central alert system were distributed to the appropriate staff and acted upon. Medicines were managed safely and staff were trained to deal with medical emergencies.

Safeguarding procedures were in place to protect children and vulnerable adults from harm. Staff were knowledgeable on safeguarding both children and vulnerable adults and knew who to report to with any concerns. There was a nominated GP safeguarding lead and there were patient registers for vulnerable adults and children.

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Systems were in place to monitor risk. Where risks had been identified control measures were in place to minimise them. Equipment used by the practice had undergone regular safety checks.

Appropriate pre-employment checks had been carried out on staff before they started working for the practice to ensure they were of suitable character.

The practice had a fire safety policy, fire protection equipment was serviced annually, nominated staff were trained as fire marshals, fire alarm checks and fire drills had been practiced regularly. However the practice had not carried out a fire risk assessment to identify actions required to maintain fire safety.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation.

Practice performance data for diabetic patients and flu immunisations were above the Clinical Commissioning Group (CCG) averages. The practice had scored 97 % in their QOF performance in the previous year and used QOF to drive practice performance.

Summary of findings

The practice had undertaken clinical audits in line with CCG recommendations. Some actions for improvement had been identified as a result of the audits and audit cycles were completed to check that performance had improved. Audits had been shared and extended to the GP practices within the network. The practice had also engaged with external consultants in relation to audits undertaken.

Staff were appropriately qualified to deliver effective care and treatment. The practice worked with other services/health care professionals to manage patients with complex needs and offered a wide range of services to promote good health. The practice participated in a Social Prescribing project, regularly engaged with Public Health England and undertook a number of health promotion activities both in house and out in the community to enable patients and members of the public to increase control over, and to improve, their health.

Are services caring?

Good

The practice is rated as good for providing caring services.

The results of the national patient survey 2014 showed that the practice scored below the CCG average for the percentage of patients who described their overall experience of the practice to be 'good.' However the results of the practices' internal patient satisfaction survey showed that 21% of patients said that the practice was either 'very good' or 'excellent' and 54 % said that the practice was 'good.' We received 47 completed Care Quality Commission patient comment cards and the vast majority of these stated that the service was 'good', 'very good' or 'excellent.'

Feedback from patients during the inspection was mostly positive about the services they received. Patients told us that staff were caring and treated them with dignity and respect and this was reflected in the CQC comment cards. We also observed this during the inspection and saw that patient confidentiality was maintained.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

The Clinical Lead and the Network Lead/Contract Manager had analysed the Joint Strategic Needs Assessment data and the priorities of the Clinical Commissioning Group (CCG) and local authority. The practice had planned services to meet the needs of

Summary of findings

the local population. These included extended hours for appointments, diabetes clinics and substance misuse services. The practice opening hours were 8am-8pm Monday to Friday and 9am-5pm on Saturdays.

The practice had recognised the needs of different groups in the planning of its services. For example, bi-lingual staff were recruited to the practice that were able to speak Bengali and patients also had access to a Health Advocacy and Interpreting Service to help them with their communication needs. The practice premises and facilities were accessible for patients with disabilities.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG) and had a system in place for handling concerns and complaints. Patients' complaints had been acknowledged and resolved in a timely manner.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led. The practice had a clear vision and strategy to go beyond clinical outcomes and support patients in a holistic sense taking into account and addressing wider issues such as housing, education and other social issues and health determinants. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. Staff were able to articulate the vision of the practice and worked as a team to achieve this.

Governance arrangements were in place including policies and procedures to govern activity and defined roles for staff and lines of accountability. Policies and procedures were proactively reviewed and took account of current models of best practice within the GP network. The practice chaired the GP Network meetings which provided peer to peer support, challenge and training for staff from five GP practices.

The practice carried out proactive succession planning and developed internal staff members with the potential to fill key leadership roles within the practice. Clinical staff had weekly protected time for mentoring. Mentoring sessions included discussions on referrals, results and prescribing and provided an opportunity for personal development and career progression.

Regular staff meetings were held and staff received training and support to carry out their job roles effectively, including annual appraisal.

Summary of findings

There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

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

Outstanding ☆

The practice was rated Outstanding for the domains of effective, responsive and well-led. The evidence which led to these ratings apply to everyone using the practice, including this population group, which has led to the Outstanding rating for the Older People population group. Patients over the age of 75 years of age were provided with a named GP and care plans were developed for these patients. Care and treatment was planned with appropriate reviews to meet the identified needs of patients. There was a proactive call and recall system in place to provide preventative and continuing care for patients. The practice's performance for seasonal flu targets for patients over the age of 65 years of age was 83% which was above the national average of 73%. The practice was responsive to the needs of older people and allocated two appointments each day for home visits to patients who were housebound with a dedicated GP providing this service. Routine planned visits were also provided for patients with complex needs. There were clinical and administrative leads for integrated care, dementia and adult safeguarding. There were appropriate and effective end of life care arrangements in place.

People with long term conditions

Outstanding ☆

The practice was rated Outstanding for the domains of effective, responsive and well-led. The evidence which led to these ratings apply to everyone using the practice, including this population group, which has led to the Outstanding rating for the People with Long Term Conditions population group. The practice provided clinics for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). The practice nurses led clinics for long term conditions and care plans were developed for all patients with long term conditions. All patients with long term conditions also had a named GP and annual reviews were carried out to check that their health and medication needs were being met in line with best practice. There was a proactive call recall system in place to provide preventative and continuing care for patients. For those people with the most complex needs, the practice nurses worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had achieved 100 % of its QOF targets for the asthma, COPD and hypertension QOF indicators for the previous year and 90 % of its QOF target for the diabetes indicator.

Summary of findings

Families, children and young people

Outstanding ☆

The practice was rated Outstanding for the domains of effective, responsive and well-led. The evidence which led to these ratings apply to everyone using the practice, including this population group, which has led to the Outstanding rating for the Families, children and young people population group. There were systems in place 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 A&E attendances. Multidisciplinary team meetings were held with GPs, health visitors, social workers and children's centre staff to discuss and monitor vulnerable children under the age of 5 years of age. Regular internal meetings were held to discuss vulnerable children under the age of 16 and those on the child protection register. The lead GP attended locality child safeguarding leads meetings and a system was in place to alert staff if a child was on a child protection plan. The practice provided a range of services for families, babies, children and young people including weekly child health clinics supported by health visitors, baby immunisations, ante-natal and post-natal care and child development checks. Practice appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Outstanding ☆

The practice was rated Outstanding for the domains of effective, responsive and well-led. The evidence which led to these ratings apply to everyone using the practice, including this population group, which has led to the Outstanding rating for the Working age people (including those recently retired and students) population group. The practice provided easy access to this population group. For example appointments were available early mornings, late evenings and Saturdays for those who were working or in education. In addition the practice offered online appointment booking for this group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice was rated Outstanding for the domains of effective, responsive and well-led. The evidence which led to these ratings apply to everyone using the practice, including this population group, which has led to the Outstanding rating for the People whose circumstances may make them vulnerable population group.The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks and offered longer appointments for people with a learning disability. The practice has a high proportion of patients registered from a Bangladeshi ethnic background who did not speak

Summary of findings

English as a first language. Bi-lingual staff had been recruited to the practice, including the Patient Advisor, who could speak Bengali. Other languages spoken by patients were catered for by the practice through the use of Language Line and a Bilingual Health Advocacy and Interpreting Service. The practice had a lead GP for substance misuse. Weekly substance misuse and alcohol clinics were provided for patients and the practice worked closely with the community drugs therapy team to provide this service. As part of the practice's engagement with a social prescribing project within the borough, a Benefits Advisor provided sessions at the practice for patients requiring financial, employment and housing advice. Staff knew how to recognise signs of abuse in vulnerable adults and children and there was a lead GP for safeguarding. Staff 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)

Outstanding ☆

The practice was rated Outstanding for the domains of effective, responsive and well-led. The evidence which led to these ratings apply to everyone using the practice, including this population group, which has led to the Outstanding rating for the People experiencing poor mental health (including people with dementia) population group. Proactive call recall systems were in place for mental health reviews and physical health checks for patients. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Practice meetings were held with the locality consultant psychiatrist and mental health nurse to discuss the care and treatment of patients. Care plans were developed and patients were provided with a named GP. The practice has a dementia lead GP and staff had received training in dementia care, the mental capacity act and capacity assessments. The practice carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with seven patients during the course of our inspection including two representatives of the Patient Participation Group (PPG). We reviewed 47 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service; the results of the practice's most recent patient experience survey and the national patient survey 2014.

All the patients we spoke with were positive about the practice and the vast majority of the CQC comment cards stated that the service was 'good', 'very good' or 'excellent.' Patients said all the staff were friendly and treated them in a respectful manner. Patients were satisfied with the practice's opening hours and the standard of care they received. The national patient survey however showed that 47 %of patients described their overall experience of the practice to be 'good' which was below the CCG average of 79 %.

Areas for improvement

Action the service SHOULD take to improve

The practice should carry out a fire risk assessment to identify actions required to maintain fire safety.

Outstanding practice

- Improvements in care for patients who use services are made as a result of ongoing monitoring and clinical audit. An example of an audit which improved care for patients was an audit based on the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for the management of patients with abnormally heavy bleeding at menstruation referred to as 'menorrhagia.' Following the audit by the practice, it was extended to practices within the GP network and gynaecology referrals were reviewed. A consultant gynaecologist was subsequently invited to a multidisciplinary meeting to discuss referral guidelines and have a case based discussion. A re-audit was subsequently undertaken which identified that the practice had managed to continue following the guidelines and had reduced their referrals to secondary care with patients appropriately managed in primary care.
- A systematic approach is taken to working with others in the health and social care economy to improve care outcomes and tackle inequalities. The practice participates in a Social Prescribing project jointly funded by MEEBBB Health CIC and Tower Hamlets CCG in which they refer patients to wider support services, activities and programmes within the borough. The practice regularly engages with Public Health England and the community drug therapies team and provides weekly Benefits Advisor sessions for patients. The practice undertakes a number of health promotion activities both in house and out in the community to enable patients and members of the public to increase control over, and to improve, their health.
- The practice had analysed the Joint Strategic Needs Assessment data and the priorities of the Clinical Commissioning Group (CCG) and local authority in the planning of its services to meet the needs of the local population. These included extended hours for appointments, diabetes clinics and substance misuse services. The practice opening hours were 8am – 8pm Monday to Friday and 9am -5pm on Saturdays. Bi-lingual staff were recruited to the practice that were able to speak Bengali to help patients with their communication needs.
- There is a strong commitment to developing skills, competence and knowledge of staff through an in practice weekly mentoring an annual learning

programme. Clinicians have weekly protected time for mentoring to discuss referrals, results and prescribing and there is an annual programme of learning for all staff. Mentoring sessions included discussions on referrals, results and prescribing and provided an opportunity for personal development and career progression. Staff are encouraged and supported by the practice to acquire new skills such as administrative in Customer Services skills, nurses had attended a diabetes care certificate training course approved by Warwick University to fulfil their role in running the diabetes clinics for patients and the Health Care assistant had undertaken flu vaccination training and was currently being supported to study for an Assistant Practitioner qualification.

There are consistently high levels of constructive staff engagement and a high level of staff satisfaction. Staff are proud of the practice and contribute to the practice's vision to go beyond clinical outcomes and support patients in a holistic way. Staff understand the practice's vision and values and knew what their responsibilities were in relation to these such as signposting patients to various services including benefits advice and food banks.

MEEBBB Health CIC (St Pauls Way Medical Centre)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included two GP Specialist Advisors and a second CQC inspector. The GP Specialist Advisors were granted the same authority to enter St Paul's Way Medical Centre as the CQC inspectors.

Background to MEEBBB Health CIC (St Pauls Way Medical Centre)

MEEBBB (Mile End East and Bromley by Bow) Health CIC (St Paul's Way Medical Centre) provides GP primary medical services to approximately 10,500 patients living in the London Borough of Tower Hamlets. The practice is a Community Interest Company run by representatives from four other local GP practices.Tower Hamlets is the seventh most deprived borough in England. The patient population served by the practice is ranked as the most deprived within Tower Hamlets. The majority of the local population speak English as a second language. Patients registered with the practice are predominantly from a Bangladeshi background. The next largest ethnic groups are patients from White and Black backgrounds. The practice serves a young population group with 63 % of patients in the 16-59 years age range and 28 % are in the under 16 year's age range.

The practice team is made up of two male and seven female GP's, one male trainee GP, two female nurse practitioners, two female practice nurses, a healthcare assistant, phlebotomist, practice manager, two deputy practice managers, a network/contract manager, network co-ordinator, patient advisor, ten receptionists and four administrative staff. The practice is accredited as a GP Training Practice and provides approximately 140 community teaching sessions per year. The practice has an Alternative Provider Medical Services (APMS) contract (APMS is one of the three contracting routes that have been available to enable commissioning of primary medical services).The practice is part of a GP network of 5 practices and within the network there are shared, joint targets for 30,000 patients living within the borough of Tower Hamlets.

The practice's opening hours are between 8.00am - 8.00pm Monday to Friday and 9:00am - 5:00pm on Saturdays. GP appointments are available between 8:00am-12:00pm, 12:30pm- 4:00pm, 4:30pm-8:00pm Monday to Friday and 9:30am-12:00pm, 1:00pm-5:00pm on Saturdays. Telephone access is available during core hours and the practice has an online appointment and repeat prescription request facility. Home visits are provided for patients who are housebound or are too ill to visit the practice.

The practice has opted out of providing out of hours (OOH) services to their own patients and refers patients to the '111' service for healthcare advice.

The practice is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury.

Detailed findings

The practice provides a range of services including clinics for patients with long-term conditions, healthy lifestyle advice, help with addictions, cervical smear tests, sexual health advice, cancer awareness, family planning, wound care, maternity care, travel advice, vaccinations and immunisations and blood pressure monitoring.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice including information published on the NHS choices website and the national patient survey 2014. We asked other organisations such as NHS England and Tower Hamlets Clinical Commissioning Group (CCG) to share what they knew about the service.

We carried out an announced visit on 26 November 2014. During our visit we spoke with a range of staff including GPs, the practice manager, network manager, nurse practitioners, the health care assistant and reception staff. We spoke with five patients who used the service and two members of the practice's Patient Participation Group. We reviewed comment cards completed by 47 patients sharing their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety, for example incident reports, complaints, safeguarding concerns and national patient safety alerts.

The number of incidents reported in the last 12 months was low but where they had occurred, investigations, outcomes and actions were clearly documented. The staff we spoke with were aware of their responsibilities to raise concerns and were able to describe the procedure for reporting incidents and near misses. Staff were able to describe a recent incident involving an altercation between patients and the steps that had been taken. Patients we spoke with during the inspection told us they felt their care and treatment at the practice was safe.

We reviewed minutes of meetings where incidents and complaints were discussed during the last 12 months and reviewed incident reports which had been collated for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant events and incidents were reported on a standardised form which included a description of the incident, what went well in handling the incident, what could have been done differently and what could be learned from the incident to prevent a reoccurrence. Staff including receptionists and administrators were aware of the process to follow and send completed incident forms via email to the management team. Staff we spoke with were able to provide an example of a recent incident reported and told us that incidents were discussed at the handover shift meetings to ensure all staff were kept informed. There were records of significant events that had occurred during the last three years and we were able to review these. An example of a significant event related to the lapse in registration of a practice nurse with the Nursing and Midwifery Council. As a result of learning from this incident, the practice had advised the nursing team to ensure that they set up a direct debit for their registration renewals, email alerts were created to prompt when a registration was coming to an end and the staff training matrix was updated by the Practice Manager more frequently to avoid further occurrences.

The practice had a significant event policy which included a process for communicating the outcome and learning to relevant staff. The GP Clinical Governance lead had responsibility for ensuring that significant events were discussed as part of the weekly clinical meetings and we saw practice meeting minutes to evidence this taking place. We saw evidence of learning as a result of a significant event which included using email as opposed to verbal handover with Health Visitors to facilitate more robust, auditable communication.

National patient safety alerts were disseminated by the Practice Manager via email to practice staff. Staff we spoke with were able to give an example of a drug safety alert that the practice actioned. The drug safety alert instructed that a medication was contraindicated for patients with cardiovascular disease. The practice actioned this safety alert by ensuring that patients with cardiovascular disease were given alternative medication and a follow up audit was undertaken to ensure that this action was completed. Staff also told us that safety alerts were discussed at weekly practice clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were safeguarding policies in place for both children and vulnerable adults which included contact details for Tower Hamlets safeguarding and social care teams. Flowcharts detailing the procedure for escalating safeguarding concerns were posted in consultation rooms for quick reference to ensure staff reported any concerns promptly.

A training matrix containing staff training records for medical, nursing and administrative staff was made available to us prior to the inspection. We also examined training records during the inspection which included certificates of training completed. The training records showed that all staff had received relevant role specific

training in child protection. All administrative staff were trained at Level 1 and all clinical staff were trained at Level 3 in accordance with national guidance. Staff had also received training in the protection of vulnerable adults.

The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. The safeguarding lead had been trained in safeguarding adults and also Level 3 child protection to enable them to fulfil this role. The practice also had a designated safeguarding administrator. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

We asked administrative staff about their most recent training. Staff we spoke with were able to describe signs of abuse in older people, vulnerable adults and children. One staff member was able to provide an example of a safeguarding concern that she escalated to the practice safeguarding lead. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Safeguarding contact details were easily accessible and were available via the reception notice board, the computer software phonebook and the safeguarding policy stored on the desktop of any computer within the practice.

There was a red alert message system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The practice had a chaperone policy and signs were visible on the reception desk notice board and in the consultation rooms offering the chaperone service. The chaperone policy contained guidelines on who could act as a chaperone, the role of the chaperone and confidentiality requirements. The policy strongly recommended that chaperoning should be provided by clinical staff familiar with procedural aspects of personal examination. However if clinical staff were not available to act as chaperones, seven receptionists had undertaken formal chaperone training at a local hospital. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff acting as chaperones present during intimate or personal examinations had undergone a criminal records check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a cold chain procedure for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a breach of these temperatures. The fridge temperature was checked and documented once a day and we saw records of these checks being undertaken for the last three years and the appropriate temperature range had been maintained.

The practice nurses were responsible for ensuring medicines were in stock and within their expiry dates. Medications due to expire in the next six to eight weeks are ordered one month in advance to ensure stock was maintained and suitable for use. Vaccines were checked weekly for their expiry dates and rotated so that vaccines closest to their expiration date would be used first. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generate prescriptions were trained and changes to patients' repeat medicines were managed. We saw evidence of prescription training was part of the administration staff induction programme. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

Good

Are services safe?

We observed the premises to be clean and tidy. The practice has a cleaning contract with an external agency and we saw evidence of cleaning task sheets and rotas. The practice manager has oversight of the cleaning contract and undertook a daily walk round of the premises to monitor the cleaning. Patients we spoke with raised no concerns about the cleanliness of the practice.

The practice has a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received infection control training within four weeks of employment at the practice as part of the induction training programme. Staff also received annual infection control updates. Minutes of practice clinical meetings showed that infection control was an agenda item and staff infection control training requirements were discussed.

We saw evidence that the lead had carried out annual infection control audits for the last two years and improvements were identified however our inspection identified that not all of these improvements were actioned. For example, the infection control audit for 2013 identified the need for a Legionella (a germ found in the environment which can contaminate water systems in buildings) risk assessment. The infection control audit for 2014 identified the same issue and this had not been actioned despite being identified in two annual audits. We discussed this with the practice and arrangements were subsequently made for a Legionella risk assessment to be provided by an external agency.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the practice had a clinical waste management protocol in place and waste was segregated, stored safely and disposed of by a professional waste company. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff informed us that all PPE and probes used in examinations were single use to minimise cross-infection risks.

There was also a protocol for needle stick injuries which included immediate actions following an injury and contact details for needle stick injury advice from local hospitals. The practice had a contract with an external agency for daily safe removal and disposal of sharps waste.

Hand washing facilities were available throughout the practice and posters were displayed above sinks with correct hand washing techniques. Alcohol wipes and hand washing sinks with hand soap were available in the treatment rooms.

Equipment

Staff told us they had the equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. The practice had a contract with an external agency to provide portable appliance testing (PAT) and calibration of equipment on a routine annual basis. Examples of equipment calibrated included blood pressure monitors and weighing scales. All portable electrical equipment displayed stickers indicating the last testing date which was February 2014.

Staffing and recruitment

During our inspection we reviewed seven staff files including three administrative staff, three clinical staff and one Health Care Assistant. All of the staff files we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, proof of address, right to work checks, references, qualifications, registration with the appropriate professional body, employment history, occupational health checks and criminal records checks through the Disclosure and Barring Service (DBS). Criminal records checks through the DBS were undertaken for all staff working at practice. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and administrative staff.

The practice provided a comprehensive induction for staff as part of part of the recruitment process. We saw induction programmes for clinical and administrative staff.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw there was a spread sheet rota system in place for all the different staffing groups to ensure that enough staff were on duty and there was an appropriate skill mix to facilitate the clinics being provided. The practice had recently employed

two full time members of the reception team and administrative staff were able to undertake reception duties if required. Staff were required to give a period of one month's notice for annual leave.

The practice always endeavoured to cover staff annual leave and sickness internally but used GP locums occasionally to maintain appointment availability where necessary. If a locum GP was required, the practice accessed a local network agency. The Clinical Lead had oversight of the process and checked the locum GP's curriculum vitae prior to any booking. A Locum Pack detailing all necessary information and contact details to work at the practice was provided for locum GPs.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the nominated health and safety representative.

We saw evidence of health and safety risk assessments where identified risks were logged in a risk assessment table. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. For example, wiring on the reception floor was identified as a hazard to staff and rated as a medium risk. The control measures documented to mitigate this risk included the removal of electrical fans from the reception area and we saw evidence that this action had been completed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Training records showed that all staff had received training in basic life support and this was provided on annual basis as part of the network training programme. Emergency equipment was available including four oxygen cylinders and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and informed us that they had also received in-house training regarding the practice's emergency equipment. We saw evidence of an emergency folder containing records which confirmed that the emergency equipment was checked regularly each week. Staff told us that the oxygen gauge of the oxygen cylinders was monitored and the battery of the defibrillator was checked on a daily basis.

Emergency medicines were available in a secure room of the practice and all staff knew of their location. Emergency medicines were checked once per month and any medications due to expire in the next six to eight weeks were ordered one month in advance to ensure stock was maintained and suitable for use. Each consulting room in the practice had an anaphylactic kit which was checked on a weekly basis. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Emergencies identified within the plan included loss of access to the building, computer systems, paper medical records, electricity and gas supplies, telephone systems and staffing issues. The business continuity plan contained a comprehensive list of contact details for staff to refer to for example electricity and gas suppliers. Staff also informed us that there was a network arrangement for emergencies in which patients could be referred to other GP practices within the network and clinical rooms of practices within the network could be utilised to see patients. There was also an arrangement in place for administrative staff to assist other practices within the network in cases of emergencies.

The practice had a fire safety policy, a fire safety log book and designated members of staff were nominated as fire marshals. Weekly fire alarm checks were undertaken and fire drills had been practiced regularly to ensure patients and staff could be evacuated in the event of a fire. An external agency provided annual fire protection equipment servicing however the inspection identified that the practice had not carried out a fire risk assessment to identify actions required to maintain fire safety.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. NICE guidelines were discussed in the weekly clinical meetings and staff we spoke to gave us an example of a recent antenatal NICE guideline that had been implemented. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We reviewed a sample of patient records including dementia, diabetic, cancer, palliative care patients and patients on the vulnerable register,

The GPs told us they led in specialist areas such as substance misuse, palliative care and mental health. The practice nurses led clinics for specific conditions such as asthma, chronic obstructive pulmonary disorder and diabetes which allowed the GPs to focus on patients within their specialist areas. Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance.

The clinical lead showed us practice performance data for diabetic patients which was above the local CCG targets. The practice had also completed a review of case notes for patients with dementia which showed all were receiving appropriate treatment and regular review. The practice used computerised tools for information regarding patients who had experienced an unplanned admission to hospital and this would be forwarded by the administration team to the patient's named GP.

The practice referred patients to secondary care and other community care services appropriately. Data showed that the practice was performing in line with CCG standards on referral rates for all conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. Patients we spoke to told us that they felt listened to in decision-making about their care.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. The practice managed the care of patients over the age of 75, patients with mental health conditions and patients receiving integrated and palliative care by allocating them a named GP. To try to improve the continuity of care of these patients, in addition to the named GP, the practice had been piloting a new system in which both patients and GPs were split into two teams, 'Blue' and 'Red.' In this way GPs were part of micro teams and if the named GP was unable to see a patient, a colleague with this team could treat the patient. This pilot had been successful and there were plans to roll out this system to the network.

The practice had achieved 97 % in their Quality and Outcomes Framework (QOF) targets in the year ending April 2014. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. QOF performance was discussed at the practice business meetings each month and an action plan was developed for each QOF target. QOF performance was also benchmarked with other practices within the network and the practice performance was one % above the local CCG average.

The practice showed us examples of clinical audits that had been undertaken over the last year. These included prescribing, referrals to secondary care, A&E attendance, use of diagnostic tests, unplanned admissions, cancer care, and infection control. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, in response to a drug safety alert issued by the Medicines and Healthcare Products Regulatory Agency (MHRA), the practice undertook an audit to identify patients with cardiovascular disease for which this medication was contraindicated. Following the audit, the GPs carried out medication reviews for patients who were prescribed this medicine and altered their prescribing practice, in line with the guidelines. This audit was repeated six months later and the audit cycle

was completed. The practice also provided an example of an audit that had been undertaken by the practice and was extended to the network. This was an audit based on the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for the management of patients with abnormally heavy bleeding at menstruation referred to as 'menorrhagia.' Following the audit by the practice, it was extended to practices within the network and gynaecology referrals were reviewed. A consultant gynaecologist was then invited to a multidisciplinary meeting to discuss referral guidelines and have a case based discussion. A re-audit was subsequently undertaken which identified that the practice had managed to continue following the guidelines and had reduced their referrals to secondary care with patients appropriately managed in primary care.

The practice used a template based on the 'Gold Standards Framework' which help doctors, nurses and care assistants provide the highest possible standard of care for patients who may be in the last years of life. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Palliative care patients had a named GP and were included in the micro teams developed by the practice whereby if the patient's named GP was not available; another GP within the team was able to see the patient.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example, the practice had six weekly prescribing meetings where they reviewed comparative prescribing data with other practices and each month prescribing data was shared at network level. The practice also participated in peer review with other practices in the CCG. This was carried out through monthly network meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and infection control. We noted a good skill mix amongst the doctors with leads for safeguarding, substance misuse, sexual health, integrated care, palliative care and we noted that one doctor had an additional diploma in dermatology. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the diabetes clinics held at the practice were nurse led and nurses had attended a diabetes care certificate training course approved by Warwick University to fulfil this role.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).All staff including the trainee GP had completed an induction programme when they started working for the practice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. We saw appraisal documentation for one GP, nurse and receptionist which identified areas for development and timescales for achieving these. The practice had also recently introduced in-house appraisals for GPs in addition to the external appraisal requirements.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, the Health Care Assistant had undertaken flu vaccination training and was currently studying for an Assistant Practitioner qualification.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example children on the 'at risk' register and patients experiencing poor mental health. The multidisciplinary meeting to discuss vulnerable children was held monthly and attended by health visitors, social workers and children's centre staff. On a six weekly basis GPs met with a consultant psychiatrist to discuss care of patients with mental health conditions such as dementia. Staff felt these meetings worked well and were a useful forum for sharing important information.

The practice provided two diabetes clinics for patients each week which were led by the nurses. The nurses liaised with a diabetes consultant for advice on the care of the patients attending the clinics and also attended a multidisciplinary meeting to discuss the treatment options for patients. A

substance misuse clinic was provided at the practice on a weekly basis and the GPs worked in collaboration with the community drug therapies team to provide care for the patients accessing this clinic.

As part of a GP network, the practice attended monthly network meetings which provided a forum for peer to peer support and challenge. The network also had shared, joint targets for 30,000 patients living within the borough of Tower Hamlets.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, the practice used an electronic document management system through which letters can be received electronically from hospitals in a secure and timely manner without the need for scanning. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system worked well.

The practice had systems to provide staff with the information they needed. An electronic patient record was used by staff to coordinate, document and manage patients' care. Staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

For information posted to the practice, such as hospital patient discharge letters, one GP was nominated each day to be responsible for post received and allocated a protected session between 2-5pm to fulfil this duty. This provision facilitated urgent information received by post to be actioned on the same day.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. Formal training in the Mental Capacity Act 2005 had been undertaken by GPs, nurses and senior administrative staff. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example we saw evidence of mental capacity assessments being undertaken and the outcomes clearly documented.

GPs demonstrated an understanding of both Gillick and Fraser guidelines (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge). Staff we spoke with had not encountered a patient case to apply this guideline but had received training in Gillick competencies.

Patients with a learning disability and those with dementia were supported to make treatment decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's 'Wishes for care/care plan' for their preferences and decisions for treatment.

Health promotion and prevention

The Clinical Lead and the Network Lead had analysed the Joint Strategic Needs Assessment (JSNA) data and the priorities of the Clinical Commissioning Group (CCG) and local authority. The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns identified and these were followed-up in a timely manner. We noted GPs used appointments with patients to help maintain or improve physical health and mental wellbeing. For example, by offering smoking cessation advice to patients who were smokers. The practice provides smoking cessation clinics which were led by the Health Care Assistant and supported by a smoking cessation advisor who promotes the cessation clinic. On 12th March 2014, the practice took part in the No Smoking Day campaign. The event held at the practice informed patients of the harm to the body caused by smoking and referred patients to the practice's smoking cessation clinic. Patients who attended this event fed back to staff that they found the graphics used in the display to be very powerful, the illustration of the financial savings was very motivational and they felt empowered to make an informed decision to quit smoking. The event was attended by approximately 45-50 patients of whom 20 expressed an interest to quit smoking and were referred to the smoking cessation clinic. The practice also made patients aware of other specialist services in the borough, such as the

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Bangladeshi Stop Tobacco Project. As part of the No Smoking Day 2014 campaign, Public Health hosted a competition for the best stop smoking displays in the GP practices. All of the practices in the borough of Tower Hamlets took part in this competition and the practice won first place for this award.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and offered patients an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. For example, the practice had an in-house dietician who provided dietary advice for obese patients. The practice also promoted healthy eating by holding workshops every six months at a local café and signposted patients to various services according to which health changes they want to make. Staff also told us that the trainee GP had been given an opportunity to visit a local nursery and taught three to four year old children about healthy eating. In addition to providing healthy eating workshops in the community, the practice held a number of in-house workshops including a 'Spring into Health' workshop which promoted general health and wellbeing, a retinal screening workshop for patients with diabetes and an immunisation event which invited parents to attend with their children to inform them if their children were up to date with their immunisations and provided them with immunisation information.

The practice also engaged regularly with Public Health England (PHE) and during our inspection we observed a PHE worker providing sexual health information to patients in the waiting area. There was a range of information leaflets and posters in the reception and waiting area such as an English speaking group for fathers, 'Take flu seriously,' Breastfeeding', 'Toy House' - parent and baby drop-in centre and religious and cultural male circumcision services. Health promotion information was also projected on the television monitor in the waiting area.

The practice's QOF target for cervical smear uptake was 80% and the practice had achieved 86% in the 2013/14 QOF performance which was four % above the local CCG target. Telephone reminders were offered for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. Breast screening uptake for the practice was 63.3 % which was below the local CCG average of 67.8 % and the England average of 76.3 %. To try to improve the patient uptake of breast screening, the practice had worked with a breast cancer charity, "Bosom Buddies" who assisted the practice by telephoning patients to reminding them to attend their appointment, provided support for patients who were unsure whether to attend or not and discussed any anxieties that patients had, accompanied patients to their appointments if they did not feel confident to attend by themselves and provided information leaflets and DVD's for patients who were being screened for the very first time. Bowel cancer screening uptake for the practice was 52% which was below the national target of 60%. To try to improve the patient uptake of bowel cancer screening the practice had worked with the bowel cancer screening hub and held three educational sessions for patients who were due to have bowel screening as well as those who failed to return their bowel cancer screening test kit. These sessions were focused on delivering information on the importance of screening and how to use the kit.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had not met the 95 % target for childhood immunisations for the 12 month and five year old patient cohort, achieving 92% and 83 % respectively. However, the practice had developed an action plan to reach this target and this was disseminated in the business, reception and clinical team meetings. The practice's performance for seasonal flu targets for patients over the age of 65 years of age was 83% which was above the national average of 73%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and the last patient satisfaction survey carried out by the practice. We spoke to seven patients during our inspection and we received 47 Care Quality Commission (CQC) comment cards completed by patients to provide us with feedback on the practice.

The evidence from all these sources showed a mixed response in the level of satisfaction of patients with their GP practice. The results of the practice patient satisfaction survey showed that of the 100 responses received, 21 % of patients said that the practice was either 'very good' or 'excellent' and 54% said that the practice was 'good.' We received 47 comment cards and the vast majority of these stated that the service was 'good', 'very good' or 'excellent.' The national patient survey however showed that 47 %of patients described their overall experience of the practice to be 'good' which was below the CCG average of 79 %. To try to improve patient's overall experience, the practice had organised coffee mornings for patients to speak to a member of the management team; any patients that seemed like they were unable to stand or had difficulty walking were called to the reception desk quicker; and the Practice Manager had provided front line staff with training on customer service skills.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk in a back office which helped keep patient information private. Staff gave us examples of how they ensure patient privacy was maintained which included avoiding discussions with patients about the reason for their appointment at the reception desk and communicating with colleagues about patients using their patient number instead of patient names. The practice had a screened off area near to the reception which staff said could be utilised if a patient wished to have a private discussion with a member of the reception team and this would prevent patients overhearing potentially private conversations. It could also be used for breastfeeding mothers if they wished it.

We received 47 completed cards and the majority of these were positive about the service experienced. Patients said they felt the practice offered a good service and both clinical and administrative staff were helpful and caring. They said staff treated them with dignity and respect. We noted an example of compassion demonstrated by practice staff in offering the use of the staff car park for a patient with an autistic child to aid her entering the building. Four of the 47 comment cards indicated that patients sometimes experienced difficulty in getting an appointment. We also spoke with 7 patients on the day of our inspection and they told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

The practice serves a population living in a deprived borough with a high proportion of patients living in social housing and receiving housing benefits. The vision of the practice was to provide holistic care for patients going beyond clinical outcomes and supporting patients with wider issues such as housing and education. An example of this holistic care included the practice's participation in a Social Prescribing project funded by the Tower Hamlets CCG in which patients were referred to wider support services, activities and programmes within the borough.

Care planning and involvement in decisions about care and treatment

The results of the national patient survey 2014 showed that the practice scored below the CCG average for the percentage of patients who said the GPs were good at listening to them (76%), explaining tests and treatments (68%) and involving them in decisions about their care (59%). However, during our inspection patients said the GPs and nurse involved them in decisions about their care and treatments and this was reflected in the CQC comment cards we received. To try to improve patient's overall experience, the practice had organised coffee mornings for patients to speak to a member of the management team and this had been advertised in the practice and members

Good

Are services caring?

of PPG were also invited to attend. GPs were able to demonstrate an understanding of Gillick guidelines used to help clinicians decide whether a child under 16 years has the legal capacity to consent to medical examination and treatment without the need for parental permission or knowledge.

An interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care.

Patient/carer support to cope emotionally with care and treatment

Palliative care patients were given the Clinical Lead's mobile telephone number for support to cope emotionally with care and treatment.

We observed leaflets in the waiting area such as a 'Helpful Guide for Bereavement' which informed patients how to access a number of support groups and organisations. Staff told us that if families had suffered bereavement, condolence cards were sent from the practice and they were contacted and offered support.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The Clinical Lead and the Network Lead had analysed the Joint Strategic Needs Assessment data and the priorities of the Clinical Commissioning Group (CCG) and local authority. The practice also engaged regularly with Public Health England (PHE) and during our inspection we observed a PHE worker providing sexual health information to patients in the waiting area.

The practice serves a young population group with 63 % of patients in the 16-59 years age range and 28 % in the under 16 year's age range. To meet the needs of the working age and student population, the practice offered evening appointments during the week and appointments from 9:30am-12:00pm and 1:00pm-5:00pm on Saturdays. Staff we spoke to told us that a large proportion of patients registered with the practice were young mothers. In response to this population need, the practice introduced in-house ante-natal clinics.

Tower Hamlets is the seventh most deprived borough in England. The patient population served by the practice is ranked as the most deprived within Tower Hamlets. To meet the social needs of the registered patients the practice has arranged for a Benefits Advisor to deliver weekly sessions in the centre to provide benefits advice for patients. Some staff members had also attended a Food Bank course and the practice held food bank vouchers to provide for patients.

The practice had a high prevalence of patients with diabetes with approximately 600 diagnosed with the condition. To meet the needs of these patients the practice provided nurse led diabetes clinics and nurses had been trained to a high standard undertaking a diabetes care certificate training course approved by Warwick University. The practice nurses we spoke to also informed us that they engaged regularly with a diabetes consultant to discuss patients with diabetes on their caseload.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPG's work in partnership with their practice contribute to the continuous improvement of services and foster improved communication between patients and the practice. For example, the PPG suggested that the practice should offer more appointments available online. In response to this suggestion, the practice released more next day appointments online and included more routine pre-bookable appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The majority of the local population of Tower Hamlets spoke English as a second language. 48% of patients registered with the practice are from a Bangladeshi ethnic background. To meet the needs of these patients, the practice had recruited bi-lingual staff, including the Patient Advisor, who could speak Bengali. The practice could cater for other different languages through the use of Language Line and a local Bilingual Health Advocacy and Interpreting Service.

The practice provided equality and diversity training through the network educational programme. Staff we spoke with confirmed that they had completed the equality and diversity training in January 2014.

The practice premises had been adapted to meet the needs of patients with disabilities. The entrance and toilets were accessible for wheelchair users, there was a low level reception desk and all consultation rooms were situated on the ground floor. The practice also had a deaf loop system available.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Staff told us that if a homeless person attended the practice and required immediate care they would be treated at the practice. However if care required was not immediate, they would refer them to a local practice which registered homeless people.

Access to the service

The practice opening hours were between 8.00am-8.00pm Monday to Friday and 9:00am-5:00pm on Saturdays. GP appointments were available between 8:00am-12:00pm,

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

12:30pm-4:00pm, 4:30pm-8:00pm Monday to Friday and 9:30am-12:00pm, 1:00pm-5:00pm on Saturdays. Patients could book appointments by telephone, online and in person. Appointments were generally 12 minutes in length however longer appointments were also available for people who needed them and those with long-term conditions. For example, patients with learning disabilities were offered 30 minute appointments.

Telephone access was available during core hours and patients were triaged for appointments. For urgent appointments patients were triaged and seen on the same day. The appointment system had availability for urgent appointments each day. Patients we spoke to confirmed that they could see a doctor on the same day if they needed to. For non-urgent appointments patients would be provided with an appointment within 2 weeks. From 8pm pre-bookable appointments were released for patients to book appointments online.

Two appointments each day were allocated for home visits to patients who were housebound and there was a dedicated GP to provide this service. Routine planned visits were also provided for patients with complex needs.

Patients we spoke with were happy with the opening hours of the practice. This was reflected in the results of the national patient survey which found that 79% were satisfied with the opening hours. The extended hours and the facility to book appointments online catered for the needs of the working age and student patient population. The practice also used a messaging service which sent patients appointment reminders via text message to mobile telephones. Repeat prescriptions could also be requested online and were available for collection within 48 hours.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients telephoned the practice when it was closed, an answerphone message gave information on the out-of-hours '111' service.

The practice monitored the appointment system and needs of the patients by undertaking regular 'Did Not Attend' (DNA) appointment audits.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The Practice Manager was the designated responsible person who managed all non-clinical complaints and the Clinical Lead managed all clinical complaints in the practice. The practice also employed a full time Patient Advisor who was first point of contact for patients who wished to make a complaint.

We saw that the complaints procedure was displayed on posters in the reception area and there was a complaints leaflet to help patients understand the complaints system. The practice had a complaints policy and maintained a complaints log.

We looked at the complaints log for the last 12 months which recorded complaints received verbally, via email and in writing. We reviewed eight complaints received via the practice email address that was introduced in May 2014 and found that these were satisfactorily handled. In response to complaints regarding reception staff, the practice arranged for the team to attend a Customer Services training course in October 2014. At the time of our inspection the practice had no outstanding complaints being dealt with and there were no serious clinical complaints received in the last 12 months.

The practice reviewed complaints annually to detect themes or trends. We looked at the complaint summary report for the last year and themes identified included access, appointments and waiting times. Lessons learned and actions taken in response to the complaints received were documented and we saw practice meeting minutes to evidence complaints being discussed and shared with staff.

Are services well-led?

Outstanding ☆

(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 provide a model of care that went beyond clinical outcomes and would support patients in a holistic sense taking into account and addressing wider issues such as housing, education and other social issues and health determinants. We found details of the vision in the practice leaflet for patients and on the practice website.

We spoke with a cross section of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at a presentation developed for the practice away day held in June 2013 and saw that staff had discussed the vision and the aims were still current. The clinical lead told us that the practice monitored progress with the vision through its meetings with the local social prescribing team and by tracking the practice's performance with clinical outcomes.

The practice was currently working in collaboration with the East London Business Association to develop a new business plan. The Clinical Lead informed us that the strategy for the future development of the practice included establishing GP partners and re-locating to a new site in a year's time to develop the services offered by the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The policies were reviewed annually and the network shared policies to ensure best practice. All of the nine policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GP leads for safeguarding, substance misuse and palliative care. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported, there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The overall QOF score for this practice showed it was performing one % above the CCG average and three % above the England average. Staff we spoke to told us that QOF dashboard data was regularly discussed each month at clinical meetings and development plans were produced to improve targets. The practice also held an annual clinical meeting to discuss QOF and plan activities for the forthcoming year.

We saw evidence of a clinical governance work plan which was developed in April 2014 and discussed at a practice team meeting. Within the work plan, areas risk assessed included safety, clinical effectiveness, governance, employment, staff support, information management, patient experience, leadership, team working and integration and chronic disease management. The work plan also identified areas for improvement and action. For example, the implementation of an infection control lead and significant events as an agenda item in clinical meetings.

The practice chaired a monthly GP network meeting which provided a forum for peer to peer support and challenge and an opportunity to measure its service against others and identify areas for improvement.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had arrangements for identifying, recording and managing risks. We saw evidence of a risk log, which addressed a wide range of potential issues, such as patients leaving urine samples at reception. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

The practice had a programme for practice team meetings. Reception meetings were held regularly every two weeks and staff told us that in addition to these meetings, ad hoc meetings were also held as required and handover meetings were held daily with shift changes of staff. Clinical meetings were held every Friday. We saw that the clinical meetings were scheduled as part of the staff rota. In addition to the clinical meetings, there was a weekly

Are services well-led?

Outstanding ☆

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

mentoring programme in place for clinicians. All practice meetings were minuted, emailed to staff and stored on the computer hard drive. In addition to team meetings we also noted that team away days were held every two years.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. One staff member told us that they had recently suggested a more rigid schedule to cover reception during lunch breaks and that this had been actioned. We reviewed a number of policies and procedures, for example recruitment, induction and staff appraisal which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice also had a whistleblowing policy which was available to all staff electronically on any computer within the practice. Staff were aware of the whistleblowing policy if they wished to raise any concerns.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, the practice email, NHS Choices and complaints received. We looked at the results of the annual patient survey and 87% of patients said that the last appointment they had was convenient however only 29 % found it easy to get through to the practice by phone. As a result of this feedback the practice plans to introduce a new telephone system in December 2014. The telephone system will have four incoming lines, six outgoing lines and the facility for up to ten callers to be on hold which management will able to monitor. New voice messages will be incorporated including informing the caller of their place in the queue and options to hear messages in Bengali. In conjunction with the new telephone system, a telephone policy was being developed for staff. The practice had also introduced an online appointment booking system and patients we spoke to told us that this had improved access to appointments.

The clinical lead provided examples of other improvements that had been made to the practice as a result of patient feedback which included a television screen in the waiting area, an LED scrolling message system for patient appointments, a board informing patients if a GP was running late with appointments and customer services training for reception staff.

We saw evidence of practice meeting minutes where patient complaints were discussed and staff we spoke to told us that comments made on NHS Choices were also monitored and discussed within the team.

The practice had an active patient participation group (PPG) of approximately 20 members. PPG's work in partnership with their practice contribute to the continuous improvement of services and foster improved communication between patients and the practice. Membership of the practice PPG was offered to patients in two options; 'core membership' which involved attendance at meetings and 'virtual membership' where patients could be involved via email, text, telephone, letters or Facebook. During our inspection we met with two PPG members who informed us that the PPG was representative of both the ethnic population and age groups served by the practice including young mothers and Bangladeshi patients.

The PPG met every six to eight weeks at the community centre and was attended by the clinical lead and practice manager. The practice commissioned an internal patient survey 2013 which was developed with the PPG in order to improve patient care. Two of the PPG members we met during our inspection told us that the PPG added two additional questions to the patient survey. The results and actions agreed from this survey were discussed with the PPG and were available on the practice website. We saw evidence that actions resulting from the patient survey had been carried out.

The practice had gathered feedback from staff through staff meetings and away days. The practice away days are held every two years. We saw evidence of staff being asked for their ideas on how to improve the practice in the away day presentation held in June 2013. The group work sessions for the away day included how to improve access and prescribing targets, the patient experience and communication within the practice team. We also saw evidence of actions plans created after team meetings. Staff told us their managers were approachable and they felt comfortable to give feedback and discuss any concerns or issues. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice allocated protected time for

Are services well-led?

Outstanding ☆

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

clinicians on a weekly basis for mentoring which included discussions on referrals, results and prescribing and provided an opportunity for personal development and career progression.

We looked at three staff records including a GP, nurse and receptionist and saw that regular appraisals took place which identified areas for development with timescales for achieving these.

Staff told us that the practice was very supportive of training and development. Reception staff told us the practice manager informed the team via email of training courses available and one member of the team had trained to provide phlebotomy for the practice. The practice nurses had undertaken the Warwick University diabetic training course and the Health Care Assistant was currently training to become an assistant practitioner.

The practice was a GP training practice accredited to provide training for GP speciality registrars (GPSTRs). The first GP trainee started at the practice in August 2014. The practice had also formed links with a local hospital and Barts and The London School of Medicine and Dentistry and taught approximately 140 community teaching sessions per year.

The practice had completed reviews of significant events and other incidents which included lessons learned. We saw evidence that significant events were discussed at practice meetings and the lessons learned were shared with staff to ensure the practice to ensure the practice improved outcomes for patients.