Inclusion Healthcare Social Enterprise CIC

Quality Report

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

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
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

Inclusion Healthcare Social Enterprise CIC provides high quality primary health care services for homeless people. This included patients who were vulnerably housed, rough sleepers, squatters or sofa surfed in Leicester. It is based at Charles Berry House which was converted for purpose and provides an excellent city centre venue, close to public transport. It is purpose built with eight consultation rooms and separate entrances for patients and staff.

We carried out a comprehensive inspection on 6 November 2014.

We rated the practice as Outstanding. An effective, responsive and well-led service is provided that meets the needs of the population group it serves.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from safety risks.
- There were systems in place to keep patients safe from the risk and spread of infection.
- The practice was responsive to the differing needs of its patient population.
- We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.
- Patients were treated with compassion, dignity and respect.
- To reduce 'Do Not attend' (DNA) rates a health care assistant attended appointments with the patient if requested to act as an advocate.
- The practice had a clear vision to improve the health of vulnerable and excluded groups.
- There was a culture of learning and development.

We saw areas of outstanding practice including:

- Learning from the diagnosis and treatment of the patient who had taken an overdose was shared with the whole team and other external agencies. Training was then provided to external agencies and clinical staff. Information was shared with commissioners and the drug and alcohol team as a safety alert.
- Staff gave examples of how they responded to patients experiencing a mental health crisis, including

Summary of findings

supporting them to access emergency care and treatment. The practice monitored repeat prescribing for people receiving medication for mental health needs.

- Referral rates to hospital for appointments are high as the patients are homeless people with complex physical and psychological needs. Do not attend (DNA) rates are high but the practice have started to put in place a system for a health care assistant who accompanied patients to appointments if they wished. The health care assistant reminds the patients of the appointment will accompany them and be with them in the consultation room if the patient requests it.
- The practice contributed to funeral costs and memorials for patients who were homeless. They have created a memory wall at the Anchor Centre. The Anchor Centre is a 'wet' day centre for street drinkers.
- The practice had a primary care plus (PCP) nurse. A PCP nurse works with hostels, local hospitals and in the community. They provide additional support whilst homeless patients are in hospital and take an active role in ensuring that each patient's discharge from hospital runs smoothly and helps reduce inappropriate attendance at the hospitals' emergency and urgent care departments. They support patients by accompanying them to hospital appointments.
- The practice used the Human and Environmental Risk Assessment (HERA) risk stratification tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

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?

Outstanding ☆

The practice is rated as outstanding for providing safe services. This practice was safer than other similar practices and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Outstanding ☆

The practice is rated as outstanding for effective. Our findings at inspection showed systems were in place to ensure that all clinicians were not only up-to-date with both NICE guidelines and other locally agreed guidelines but we also saw evidence that confirmed that these guidelines were influencing and improving practice and outcomes for their patients. The practice was using innovative and proactive methods to improve patient outcomes and it links with other local providers to share best practice. There was an excellent system for completing and learning from clinical audit cycles with learning being shared with the practice and external organisations.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for caring. Data showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. The practice regularly engaged with many services across Leicester, for example, community health care professionals, hostel and emergency accommodation, prison and young offenders institution. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for responsive. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The

Summary of findings

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). The practice had reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients reported good access to the practice with face to face appointments always available on the day requested. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice was very active within the locality and have excellent attendance at both locality and practice learning team meetings. The practice sought feedback from patients, which included using new technology, and 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

We have not included the older people population group as the practice did not have any patients registered in this range.

Not sufficient evidence to rate

People with long term conditions

The practice is rated as outstanding for the population group of people with long term conditions.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions there were emergency processes in place. For example, care of patients with diabetes who lived in the hostel at the Dawn Centre. The practice had clinics at the Dawn Centre which gave them the opportunity to monitor this group of patients. Diabetes is made worse by levels of alcohol abuse and mental health problems.

Referrals are made for patients with long term conditions who had a sudden deterioration in health. When needed, longer appointments and visits to hostel were available. All patients with long term conditions had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice had a lead nurse for long term conditions who had completed training, for example, in lung function testing. They received ongoing training from the local hospital and had developed external links with local specialist nurses.

Outstanding

Families, children and young people

The practice are not rated for families, children and young people as they only had two children and four families registered on the day of inspection. The practice were able to see children and appointments were available outside of school hours and the premises was suitable for children and babies. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Not sufficient evidence to rate

Working age people (including those recently retired and students)

The practice is rated as outstanding for the population group of working-age people (including those recently retired and students).

Outstanding

Summary of findings

The practice used the Human and Environmental Risk Assessment (HERA) risk stratification tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice had a primary care plus nurse who worked as the interface between primary and secondary care and other agencies such as social care. She provided a communication link for patients being admitted and discharged from hospital. This helped ensure a safe admission and discharge for the patient.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable.

Referral rates to hospital for appointments were above average compared to the local clinical commissioning group (CCG) but the patients were high demand, homeless people with complex physical and psychological problems.

Do not attend (DNA) rates were also above average compared to the local CCG but the practice had started to put in place a system for a health care assistant to attend appointments with the patient. They supported vulnerable patients to access information and services. The health care assistant reminded the patient of their appointment, would accompany them and be with them in the consultation room if the patient requested it.

The practice held a register of patients living in vulnerable circumstances including homeless people, refugees and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Summary of findings

The consultant nurse and senior practice nurse went out with Leicester City Council Homeless Outreach team every six months to visit people who slept rough. They offered brief health assessments and supported people to register with the practice where appropriate.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the population group of people experiencing poor mental health.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. This was a system in place and the practice had a close working partnership with the mental health team who were available from Monday to Friday each week. Mental Health Crisis was managed in partnership with the Mental Health Crisis team. At weekends the out-of-hours (OOH) service had access to the records and the most at risk notified to OOH at the end of the day and at weekends. The practice monitored repeat prescribing for people receiving medication for mental health needs.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. MIND is a mental health charity in England and Wales offering information and advice to people with mental health problems.

The practice had a system in place to follow up on patients who had attended the accident and emergency department where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with five patients who had attended the surgery for a consultation with a GP or nurse during our inspection and two members of the patient participation group (PPG). The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

Patients told us they were very happy about the service provided by the staff. They felt included in decision making, listened to and respected. They felt they were able to express opinions, which were taken into account. Patients felt more able to cope after being seen at the practice.

Patients told us that communication between the practice and other health care settings was good.

We reviewed 20 comment cards that had been completed and left in a CQC comments box. The comment cards enabled patients to express their views on the care and treatment received.

19 of the comment cards reviewed were positive. Patients felt that the practice met the needs of the patients it served. They also felt that staff were polite and helpful, and the practice was safe and hygienic.

One of the comments cards reviewed was negative in respect of getting an appointment and the need for more than one doctor who is able to see children. We discussed this issue with the management team who said they would relook at the appointments for children who were patients.

The chair of the PPG told us that all the staff responded compassionately and were very caring. They felt the practice was well led and put their patients first.

Outstanding practice

Learning from the diagnosis and treatment of the patient who had taken an overdose was shared with the whole team and other external agencies. Training was then provided to external agencies and clinical staff. Information was shared with commissioners and the drug and alcohol team as a safety alert.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice monitored repeat prescribing for people receiving medication for mental health needs.

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The practice contributed to the funeral costs and memorials for patients who were homeless. They have supported patients to keep a memory wall at the Anchor Centre. The Anchor Centre is a 'wet' day centre for street drinkers.

The practice had a primary care plus (PCP) nurse. A PCP nurse works with hostels, local hospitals and in the community. They provide additional support whilst homeless patients are in hospital and take an active role in ensuring that each patient's discharge from hospital runs smoothly and helps reduce inappropriate attendance at the hospitals' emergency and urgent care departments. They support patients by accompanying them to hospital appointments.

The practice used the Human and Environmental Risk Assessment (HERA) risk stratification tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

Summary of findings

The practice had a strong learning culture. It had a clear vision to improve the health of vulnerable and excluded groups through the provision of high quality and responsive healthcare. It was developed with all staff and patient involvement. They also designed the practice logo.

Inclusion Healthcare Social Enterprise CIC

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 a GP specialist adviser, a second CQC Inspector, a practice nurse specialist adviser and a CQC pharmacist inspector.

Background to Inclusion Healthcare Social Enterprise CIC

Inclusion Healthcare provides high quality primary health care service for homeless and for those vulnerably housed people in Leicester. It is a social enterprise which tackles social problems, improves communities and people's life chances.

It is based at Charles Berry House and provides a city centre venue, close to public transport. It is purpose built with eight consultation rooms and a separate entrance for patients and staff. We found that patient focus was very strong and the practice had good links to many external agencies.

Inclusion Healthcare is run by a Chief Executive and three directors. The clinical team is led by a GP and consists of a Consultant Nurse, three female and one male part time GP's, two practice nurses, a primary care plus (PCP) nurse, specialist alcohol worker and a health care worker. It is supported by an administrative team. A PCP nurse works with hostels, local hospitals and in the community. They provide additional support whilst homeless patients are in hospital and take an active role in ensuring that each patients discharge from hospital runs smoothly and helps reduce inappropriate attendance at the hospital's emergency and urgent care departments

The practice is an accredited training practice with the East Midland Local Education and Training Board and at the time of our inspection had one GP registrars (fully qualified doctors who wish to become general practitioners).

The practice is located within the area covered by NHS Leicester City Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

Inclusion Healthcare recently came second and highly commended in the Health Service Journal (HSJ) awards for Compassionate Care. The HSJ gave the award for services that genuinely put patients at the heart of their care. It celebrated excellence in putting patients first, engaging patients and families in their care, listen to views and ensure people are treated with care and compassion.

We spoke with five patients including two members of the Patient Participation Group (PPG). The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We spoke with clinical, administrative staff and members of the management team. We also spoke with external partners. We looked at a range of information we hold

about the service. We reviewed information from NHS Leicester City Clinical Commissioning Group (CCG), NHS England (NHSE), Public Health England (PHE), Healthwatch Leicestershire and NHS Choices.

Inclusion Healthcare has an Alternative Provider Medical Services Contract (APMS) contract for single homeless adults. They currently have around a 1000 patients but have a 50% to 70% turnover in a year. The APMS contract allows NHS England to contract with 'any person' under local commissioning arrangements.

We inspected the following location where regulated activities are provided:-

Charles Berry House, 45 East Bond St, Leicester.LE1 4SX

Clinics are provided at Charles Berry House from 8.30 to 11.30am and 2pm to 4.30pm. Nurse and GP clinics are held each day with the exception of Tuesday where there is no GP clinic.

We also visited the following branch location where regulated activities are provided :-

The Dawn Centre, Conduit St, Leicester.LE2 OJN

The Dawn Centre is run by Leicester City Council and is a project for homeless people providing support, advice and assistance. Inclusion Healthcare provides a drop-in nurse clinic from 8.30am-11.30am each morning Monday to Friday. There is a GP service on a Tuesday morning.

Inclusion Healthcare's vision is to improve the health and wellbeing of homeless and other marginalised groups of people by the delivery of responsive and high quality health care service. They aim to be a national leader in the delivery of responsive, high quality healthcare with a demonstrable record of improving the health and wellbeing of the marginalised groups they serve.

Inclusion Healthcare has opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided to Leicester City, Leicestershire and Rutland by Central Nottinghamshire Clinical Services. OOH is for when you need GP advice out of normal surgery hours, you can still phone your GP surgery but you will normally be directed to an out-of-hours service. This service is provided from 6.30pm to 8am on weekdays, and all day at weekends and on bank holidays.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

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

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

How we carried out this inspection

To get to the heart of patients' experiences of care 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. We normally look at six population groups. For this inspection we only looked at four. Families children and young people and older people were not rated. The practice had only 9 patients over 65 and none over 75 years of age.

The population groups we looked at are:

- People with long-term conditions
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Detailed findings

- Families, Children and Young People

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 6 November 2014.

During our visit we spoke with a range of staff which included the Chief Executive Officer, lead GP, consultant nurse, business and finance director, assistant practice manager, two practice nurses, primary care plus nurse, specialist alcohol worker, administrator/receptionist, health care assistant, human resource administrator and the building and premises officer.

- Inclusion Healthcare had nine patients who were over 65 but none in the over 75 age bracket. 208 patients were identified as having long term conditions.
- The practice had four families with two children under the age of 18. 960 out of the 1000 patients registered at the practice were of working age.
- All of their patients were vulnerable. 60 patients were on the practice's register as having mental health problems with a further 200 identified as having a mental health problem.

We spoke with three Dawn Centre partners, two members of the patient participation group (PPG) and three patients who used the service. The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We reviewed comment cards where patients had shared their views and experiences of the service.

Outstanding ☆

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients.

Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Learning was shared with the whole team and other external agencies. Training was then provided to external agencies and clinical staff. Information was shared with commissioners and the drug and alcohol team as a safety alert. All incidents and alerts were collated and reviewed at the six monthly clinical governance meetings which ensured that lessons were learnt and staff were kept updated..

We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 10 years and these were made available to us. A time for significant events was on the weekly clinical team meeting agenda and a dedicated meeting occurred every three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the management team who showed us the system they used to oversee they were managed and monitored. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. As an example the practice highlighted a patient who had taken an overdose and their successful treatment. This incident led to changes at the practice and the information was shared with commissioners and the drug and alcohol team as a safety alert.

National patient safety alerts were disseminated by the Chief Executive Officer and lead GP to practice staff. An email was sent to all clinical and management staff and if relevant to the substance misuse team. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for, for example, a recent alert regarding the possibility of patients presenting with the Ebola virus. They also told us and we saw that alerts were discussed at the weekly clinical team meeting to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in working age people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible. We spoke with a receptionist who was able to describe a safeguarding concern they had raised and how they had followed the correct procedure to address the concern.

The Chief Executive Officer and a clinical lead GP were the practice leads for safeguarding vulnerable adults and children. They had been trained and could demonstrate that they had the necessary training to enable them to fulfil this role. Safeguarding training was part of the practice induction programme for new staff. The majority of training was up to date and where a training update was due, it was being planned. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Information to identify risks related to patients' was available for staff on-line. Patients were coded on the

Are services safe?

SystmOne computerised patient record system. Regular in-house multi-disciplinary team meetings were held to proactively discuss safeguarding issues and patients most at risk.

There were also weekly extended multi-disciplinary and multi-agency team meetings. Attendance included senior team members from the mental health department at Leicestershire Partnership Trust, staff from the housing department at Leicester city council and the Young Men's Christian Association (YMCA). The practice had a confidentiality policy which enabled details of the people to be discussed to be circulated in advance which enabled people who attended the meeting to be able to prepare in advance.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. We spoke with the management team as the policy needed updating and the role of the chaperone needed rewording. Since the inspection we have received the updated policy.

Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone, receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system SystmOne which collated all communications about the patient including scanned copies of communications from hospitals.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. The practice staff attended the safeguarding meetings led by the social work team if needed. There was a system of alerts and follow-ups on SystmOne.

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. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions. Three members of the nursing staff were qualified as independent prescribers and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked some anonymised patient records which confirmed that the procedure was being followed. The practice had a shared care practitioner who worked in conjunction with Leicester Recovery Partnership. Leicester Recovery Partnership delivered substance misuse services for people living in Leicester City and provides support for families and carers.

The practice did not use any repeat prescription services. All prescriptions were generated by a clinician. Patient follow-ups were carried out by the recovery navigator. Recovery navigators who are members of the multi-disciplinary team carry out full assessments of patients' needs to determine the most appropriate treatment and support. Prescriptions are agreed by the GP with a monthly review. A recovery navigator helps the patient plan out their time and to draw support from various services, not simply the drug and alcohol treatment services.

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 who

generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's 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.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

Cleanliness & Infection Control

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.

The practice had 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 induction training about infection control specific to their role and there after annual updates.

The lead had carried out audits for each of the last two years and that any improvements identified for action were completed on time. Practice meeting minutes did not show the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy, for example, if a patient vomited.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella. Legionella can be transmitted to people via the inhalation of mist droplets which contain the bacteria. This is the cause of human Legionnaires' disease. The most common sources are water tanks, hot water systems, fountains and showers. We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing & Recruitment

We spoke with the business and finance director who told us that earlier this year the practice had identified and actioned the need to employ a human resources administrator. This was due to the increase in the number of employees at the practice. They told us the human resources administrator was in the process of updating all the staff files as heads of departments had previously held information relating to the staff they managed.

We looked at a sample of four staff files in order to ascertain that appropriate recruitment checks had been undertaken prior to employment. We saw some evidence of references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. However none of the files contained evidence of photographic proof of identity. The business and finance director told us they were not aware of this requirement but would implement it into their recruitment process immediately. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

Outstanding ☆

Are services safe?

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe

Monitoring Safety & 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, dealing with emergencies and equipment. The practice also had a health and safety policy.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. Risks were treated like significant events; they were all logged separately for health and safety, one for the location or satellite location. Significant accidents were also discussed in the same way as significant events, for example, violent incidents towards staff or other patients.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions there were emergency processes in place. For example, care of patients with diabetes who lived in the hostel at the Dawn Centre. The practice had the opportunity to monitor this group of patients as the condition was made worse by levels of alcohol abuse and mental health problems.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice monitored repeat prescribing for people receiving medication for mental health needs. The practice had a close working partnership with the mental health team who were available from Monday to Friday each week. Mental Health Crisis is managed in partnership with the Mental Health Crisis team. At weekends the out-of-hours (OOH) service had access to the records and the most at risk notified to OOH at the end of the day at weekends.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used 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 records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location.

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan (BCP) was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The BCP did not have the risks rated and mitigating actions recorded to reduce and manage the risk. We spoke with the lead GP and we received an updated BCP in which risks had been identified. The risks included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

The practice had a fire risk assessment which had been undertaken and included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of nurse meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, the local immunisation co-ordinator communicated new programmes and changes to schedules and these were disseminated by the lead nurse.

The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us the senior practice nurse was the dedicated lead for chronic disease management. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines and clinical meeting minutes confirmed this.

The GPs, nurses and specialist workers had the opportunity to offer longer appointments where necessary.

Referral rates to hospital for appointments were high in comparison to the local clinical commissioning group (CCG) area. This was due to patients who were homeless people with complex physical and psychological problems. Do not attend (DNA) rates were also high in comparison to the local CCG area but the practice had started to put in place a system for a health care assistant to attend with the patient to act if necessary as an advocate. The health care assistant reminded the patient of the appointment, would accompany them and be with them in the consultation room if the patient requested it. The practice told us that hospital 'Do not attend' (DNA) rates had dropped but the practice did not have any current data to confirm this..

We saw no evidence of discrimination when making care and treatment decisions. Our 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.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice showed us examples of clinical audits that had been undertaken in the last year. Six of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example "shared care opiate substitution and treatment at Inclusion Healthcare". Other examples of clinical audit included the use of pregabalin and low molecular weight heparin. Heparin is used as an anticoagulant in the treatment of blood clots

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). QOF is a national performance measurement tool. For example we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. The GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. The practice had QOF clinical targets and good control of diabetes and hypertension despite the population that they cared for. QOF is a system used to monitor the quality of services in GP practices.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a

group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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 training required by the practice ,for example, courses such as annual basic life support.

All the GP's had Royal College of General Practitioners (RCGP) substance misuse training for alcohol and drugs. The RCGP is the professional membership body for family doctors in the UK and overseas. They are committed to improving patient care, clinical standards and GP training. RCGP training. The GP's also had extra training in child health, women's health, medical education, sexual health, mental health, RCGP Hepatitis C, harm reduction.

All staff had annual appraisals. During the appraisal a personal development plan was put in place and training was identified. Staff we spoke with confirmed that the practice was proactive in providing training and funding for relevant courses, for example we spoke with a receptionist who had requested conflict resolution training and this had been facilitated.

As the practice was a training practice, doctors who were in training to be qualified as GPs offered extended appointments to see patients. They had access to a senior GP throughout the day for support. Feedback from the trainees we spoke with was extremely positive about the practice. They rated the high quality of care given to patients, and the support given by staff. Both would strongly recommend the practice clinically and for training.

Systems were in place to ensure nurses were registered with the Nursing and Midwifery Council (NMC) and GP's with the General Medical Council (GMC).

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties, for example, on administration of vaccines. Additional training had been provided, for example in the care of patients who had minor illnesses. The practice had three independent nurse prescribers. Independent nurse prescribers are specially trained nurses allowed to prescribe any licensed and unlicensed drugs within their clinical competence.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and support people with more complex needs. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no reported instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). The practice had a primary care plus nurse who works as the interface between primary and secondary care and other agencies such as social care. She provided a link for patients and ensured a safe admission and discharge for the patient.

The practice held multidisciplinary team meetings weekly to discuss the needs of complex patients e.g. those with end of life care needs or children on the at risk register.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

These meetings were attended by the nursing team, doctors, specialist alcohol worker, the independent nurse prescriber from the community and prison drug alcohol team. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used SystmOne to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner.

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

There was a practice website with information for patients including signposting services and latest news.

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. The staff were trained and supported by a GP who carried out in-house training. All the clinical staff we spoke to understood parts of the legislation and were able to describe how they implemented it in their practice.

The practice had care plans for a small number of patients with learning disabilities, and for those with alcohol and drug induced dementia. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, Intrauterine Contraceptive devices (IUCD) and implants with a record of the relevant risks, benefits and complications of the procedure. The IUCD is an effective method of contraception which is also known as 'the coil'.

The practice had not had an instance where restraint had been required in the last three years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. We found the smoking cessation work carried out by the practice was very proactive. Two members of staff had obtained qualifications to enable them to support patients to stop smoking. The practice had identified this as a high priority as many homeless patients wished to stop smoking.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 34 patients in this age group had taken up the offer of the health check. We saw excellent use of the risk stratification tool. This tool identifies factors which could be a risk before they occur, for example in urgent care and long term conditions. The practice will then develop interventions to mitigate their impact. The practice use 'HERA' and the tool covers 31 local clinical commissioning groups (CCG's) via the Greater East Midlands Commissioning Support Unit. Via SystmOne GP's, nurses and manager regularly reviewed the patients and produce shared care plans. A similar system was also used for patients who required end of life care.

All patients with a long term condition (LTC) had a named GP. The practice had carried out structured annual reviews for people with various LTCs (e.g. diabetes, COPD, heart failure). 78% of patients with diabetes had received an annual foot check. 94.5% people had their blood pressure checked. Documentation of health promotion lifestyle advice was recorded in the notes. We saw evidence of multidisciplinary case management meetings. Most patients registered with the practice had opted for the adoption of Summary Care records. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register and had six patients with learning disabilities. All were offered an annual physical health check. Practice records showed they had all received a check up in the last 12 months. The practice had also identified the smoking status of 79% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. 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.

The practice's performance for cervical smear uptake was 79.3% which was better than others in the CCG which was positive given the patient population group of the practice. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. There was a named nurse responsible for following-up patients who did not attend screening. Performance for national chlamydia screening was 100% invited of whom 28.9% were tested.

The practice offered a full range of immunisations for children in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

We saw that the practice held and actively used a register of those in various vulnerable groups for example homeless people, travellers, and people with a learning disability.

There was evidence of signposting patients to various support groups and third sector organisations such as Action Homeless, YMCA, Alcoholics Anonymous, Intercept Service and Wordsworth Road Hostel.

Patients who had poor mental health had access to a dual trained GP and psychiatrist at the practice. The practice list turnover was very high so uptake has proved difficult. The practice had a comprehensive partnership with Leicestershire Partnership Trust (LPT). They had a psychiatrist who was based at the practice for use by the patients registered on the practice list. The practice had an Improving Access to Psychological Therapies (IAPT) therapist. The therapists worked with clients who have a range of complex problems related to anxiety and depression. The practice had a specialist alcohol worker who provided counselling and support to patients who were addicted to alcohol.

The practice has weekly multi-disciplinary meetings. From this meeting, patients are signposted to third sector organisations, for example the Intercept Service. Intercept Service is for people with mental health needs in the Criminal Justice System and the Niebo Resource Centre, an East European support service.

Two GP's who worked at the practice went into the local prison three times a week during the day and also provided out of hours care for substance misuse patients. They also carried out two sessions of substance misuse in the community drug treatment team. This contract is with Drug and Alcohol Team, NHS England and Public Health England and covers substance misuse treatment. Some homeless patients go between prison and the practice's care so the practice provided an integrated system which included developing yearly care plans.

Outstanding ☆

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the July 2014 national GP patient survey. The evidence from the survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 390 patients were sent a national patient survey with 31 responses. The practice was rated as 'among the best' for patients rating the practice as good or very good. 71% said the GP was good at listening to them and gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 20 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One patients' comments were less positive but there were no common themes to these. We also spoke with patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away at reception desk and was shielded by a part glass partition which helped keep patient information private. In the national patient survey 81% of patients found the receptionists at this surgery helpful.

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

External agencies we spoke with told us that the practice was patient focussed and their understanding and empathy was outstanding.

Care planning and involvement in decisions about care and treatment

The July 2014 national GP patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area.

The results from the practice's own 2014 satisfaction survey showed that 91% of patients said they were sufficiently involved in making decisions about their care. We saw evidence that people with long term conditions had care plans. Patients had been involved and had agreed with the plan of care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 79% of respondents to the patient's participant group survey said that after seeing a GP they felt more able to cope with their problems or illness. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Outstanding ☆

Are services caring?

Notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice has previously paid for funeral costs and memorials for patients who were homeless. They have created a memory wall at the Dawn Centre. The Dawn Centre is a project for homeless people providing support, advice, assistance and temporary accommodation.

The practice has created a charity, 'INCH foundation' to support homeless people. Recently the foundation funded a day trip to the beach for a homeless person before they died. Members of the nursing team supported the patient.

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. The practice used the Human and Environmental Risk Assessment (HERA) risk stratification tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

There had been very little turnover of clinical staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

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). For example a new system had been introduced to improve appointment attendance by means of patients not being allowed to make a pre-bookable appointment if they had missed two consecutive appointments.

The practice worked collaboratively with other agencies. We saw minutes of meetings where information was shared to ensure good timely communication.

The practice has an identified lead for end of life care (EOLC).They worked with the local hospice and had a register for patients on EOLC. The practice used the local clinical commissioning group (CCG) model. The model is called 'Deciding Right – Planning your care in advance'. An 'emergency health care plan' (EHCP) was agreed with each patient together with clinicians involved in their care and any relatives or carers where appropriate. The EHCP informs healthcare professionals of the patient's wishes and any treatment they should receive.

There was information available to patients in the waiting rooms and reception area about support groups, clinics and advocacy services. There saw there was separate discreet waiting areas for patients to wait in if they so wished to do so.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. For example, arrangements were in place to ensure that patients had regular access to a GP. Some appointments with a GP were at the Dawn Centre, which was more accessible for the people who lived at the hostel.

The practice were committed to the reduction of health inequalities and the improvement in the health and wellbeing of this vulnerable population group. They worked with many organisations around Leicester to support their patients which included people who were homeless, in prison or lived in a hostel. They provided innovative compassionate care which had enabled them to address some of the wider healthcare needs of their patients, for example, mental health and/or financial problems.

The practice had access to online and telephone translation services and staff who spoke Punjabi, Urdu, Polish, Italian, Lithuanian and Russian.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities, for example, ramps into the building, accessible toilets and consulting rooms on the ground floor.

We saw that the practice had waiting areas which were 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 who attended the practice and included baby changing facilities.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Inclusion Healthcare provided a range of GP appointments. Appointments were also available with a GP registrar, consultant nurse, practice nurse and health care support worker. The practice had a full time alcohol worker with experience in substance misuse who supported patients with alcohol detoxification where appropriate.

Staff told us that the practice was flexible due to the patient population groups. Longer appointments were available for patients with complex needs. When a patient did not attend, depending on the reason for appointment, the practice contacted other agencies to ensure that the patient was safe. 90% of people in the July 2014 national GP patient survey described their experience of making an appointment as good. The practice received 82% for satisfaction on being able to get an appointment to see or speak to someone the last time they tried.

Appointments were available at Charles Berry House all day on a Monday, Wednesday and Friday and on Tuesday and Thursday afternoons. Monday to Friday from 8.30 to 12.30 at The Dawn Centre.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. However they told us they would like to be able to ring later than 8.30am to get an appointment on the day as the phone line can be extremely busy. We spoke with the management team who were aware that this could be a issue.

We reviewed information from the July 2014 national GP patient survey. 90% of respondents described their experience of making an appointment as good , 96% were able to get an appointment to see or speak to someone the last time they tried and 93% said the last appointment they got was convenient.

The practice was situated on the ground and first floor of the building with the majority of services for patients on the ground floor. Lift access was provided to the first floor. We saw that the waiting areas were 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 including baby changing facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Following the inspection we were provided with a copy of an amended copy of the complaints policy which was in line with recognised guidance and contractual obligations for GP practices in England. There was a designated person responsible who handled all complaints in the practice.

Information was provided to help patients understand the complaints system. There was a complaints procedure leaflet available to patients in the practice and some information via the website. The leaflet gave guidelines to patients as to how to raise a complaint and what they could expect from the practice in response to a complaint. There were details of advocacy support available for help with raising a complaint and details for NHS England and the Health Service Ombudsman for patients to contact if they were not satisfied with the outcome of their complaint to the practice.

None of the patients we spoke with on the day of the inspection said they had felt the need to complain or raise any concerns with the practice.

Staff we spoke with were aware of the complaints policy. They told us they would inform the lead GP if any complaints were made to them.

There had been two complaints received by the practice in the last 12 months and we saw that they had been dealt with appropriately and were responded to in a timely manner. The responses included details of any lessons to be learnt from the complaint raised and how changes would be implemented. We also saw minutes of practice

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

meetings where the learning points from complaints had been discussed with staff and saw evidence that changes to practice had been implemented as a result of complaints. For example as a result of one of the complaints a new procedure had been adopted which meant that all detoxification patients would now be given a detailed action plan with clear guidelines in order to clarify patient expectations.

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 strong learning culture. It had a clear vision to improve the health of vulnerable and excluded groups through the provision of high quality and responsive healthcare. It was developed with all staff and patient involvement. They also designed the practice logo, the starting point of which was the seven standards of public life which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

We spoke with eight members 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 minutes of the practice away day held on 15 July 2014 and saw that staff had discussed and agreed that the vision and values were still current. One member of staff we spoke with described how they felt the practice's vision and values carried through the whole staff team and made them a stronger team as a result.

Governance Arrangements

There was a management team in place to oversee the systems, ensuring they were consistent and effective. The management team were responsible for making sure policies and procedures were up to date and staff received training appropriate to their role.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at fourteen of these policies. We found that most of the policies and procedures we looked at had been reviewed were up to date. We spoke to the management team with regard to the chaperone, complaints and whistleblowing policies. Since the inspection those policies have been updated with current information and contact details.

The practice held monthly governance meetings. The practice had robust arrangements for identifying, recording and managing risks. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards despite the practice population being mostly homeless. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice used the Clinical Commissioning Group (CCG) balance scorecard. A balanced scorecard is an assurance process that NHS England has put in place to make sure patients are receiving safe, effective and high quality care. We saw evidence that the scorecard was discussed at the monthly clinical meetings.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least every four to six weeks. 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. We also noted that team away days were held every 12 months.

The business manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, induction and training which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys. We looked at the results of the annual patient survey and were told that as a result of comments made, new flooring had been laid at the Dawn Centre to help patients identify different areas.

The practice had an active patient participation group (PPG) which fluctuated in size. The PPG had been involved with patient surveys and met every six weeks. We looked at the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the

Are services well-led?

Outstanding ☆

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

practice website. Online Booking was now being actively advertised and the practice had seen an increase. Waiting times had been added to the electronic notice board to keep patients informed.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had made a suggestion regarding the appointment system which had been listened to and implemented. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice.

External agencies told us the practice was outstanding, well-led, approachable and available all the time. They were flexible within their own parameters to reach the most vulnerable patients.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice is a GP training practice. We spoke to a GP Trainee and a past GP trainee. They attended weekly multi-disciplinary meetings at the Dawn Centre and in-house meetings on a Wednesday lunchtime for all staff. Patients with more complex needs were discussed, for example, their treatment and care plan. This gave the trainees an opportunity to discuss a significant event that they had experienced. The learning and change in practice involved a change in medication alongside partnership working with colleagues from the medicine managements department at NHS England local area team. Both trainees strongly recommended the practice both clinically and for training.