The Doctor Hickey Surgery

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

Key findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Outstanding overall.
(Previous inspection May 2015 – Outstanding)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Outstanding

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

Older People – As the number of patients in this group was low we did not rate this population group

People with long-term conditions – Outstanding

Families, children and young people – As the practice did not provide services to this group we did not rate this population group

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

People whose circumstances may make them vulnerable – Outstanding

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

We carried out an announced comprehensive inspection at The Doctor Hickey Surgery on 8 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- A proactive approach to anticipating and managing risks to people who use their services was embedded and was recognised as the responsibility of all staff.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills and share best practice.
- Staff involved and treated patients with compassion, kindness, dignity and respect. Patients were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from

Summary of findings

patients. Staff recognised that patients need to have access to, and links with, their advocacy and support networks in the community and they supported patients to do this.
- Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility, choice and continuity of care.
- The practice had a clear vision which had quality and safety as the top priorities. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plan were aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. There was a fully embedded and systematic approach to improvement. Improvement was seen as the way to deal with performance and for the organisation to learn.

We saw several areas of outstanding practice including:

- At our previous inspection in May 2015 we reported that the practice had entered into a partnership with a local food business who provided sandwiches daily for their patients. We found this partnership was continuing at our latest inspection. Patients we spoke with told us they especially welcomed this hospitality and the hot drinks provided daily at the practice.
- Since the previous inspection the practice had secured funding from a local community health charitable trust to provide patients with vouchers for 'Health and Wellbeing Packs' to meet the most immediate needs of rough sleepers. The packs contained items including food vouchers, basic clothing, toiletries, sleeping bags, dental and podiatry hygiene packs, wellbeing and local services information, and simple medicines, including analgesics and vitamins for patients.
- The practice continued to run the Street Doctor Program which was in place at our previous inspection. This was a medical outreach project where GPs and practice staff alongside the City Council outreach teams would carry out night walks through the local streets and parks. They spoke with rough sleepers, identified their medical needs and addressed those needs in ways which were likely to improve both their general health and their ability to utilise general homelessness services, with the ultimate aim of permanent resettlement. The practice regarded entrenched rough sleepers, people who have been rough sleeping for a long time, usually because of major psychoses, as especially vulnerable. They required prolonged and patient engagement, which the practice provided in association with the Westminster City Council specialist outreach service for entrenched rough sleepers.
- The practice participated in a Homeless Health Peer Advocacy project commissioned by Central London CCG which aims to help improve the health of currently homeless people - primarily through charity based Peer Advocates offering one to one support to help access health services by accompanying people to appointments. Advocates all have personal experience of homelessness and are recruited from existing volunteering schemes or are people who are interested in developing a career in the health and social care field. Two trained advocates were based at the practice and the practice told us utilising this service had greatly assisted its 'inreach' program to the major hostels and day centres in South Westminster.

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

- Review progress on the arrangements for an externally provided health and safety check of the practice premises and equipment to ensure its completion and implementation of actions identified.
- Review the practice's infection control policy to consider the inclusion of the assessment of patients with presumed sepsis and raising awareness among the reception team of symptoms that might be reported by patients and how to respond.
- Continue to review cervical screening uptake with a view to securing further improvement.

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

Summary of findings

The six population groups and what we found

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

Older people	**Not sufficient evidence to rate**
People with long term conditions	**Outstanding** ☆
Families, children and young people	
Working age people (including those recently retired and students)	**Outstanding** ☆
People whose circumstances may make them vulnerable	**Outstanding** ☆
People experiencing poor mental health (including people with dementia)	**Outstanding** ☆

The Doctor Hickey Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and an expert by experience.

Background to The Doctor Hickey Surgery

The Doctor Hickey Surgery provides GP primary care services to approximately 2,350 homeless people in Westminster. The practice is staffed by four GPs, two male and two female who work a combination of full and part-time hours. The practice employs one nurse (an advanced nurse practitioner), a case manager, a practice manager, three administrative staff and two cleaners.

The practice holds a Personal Medical Services (PMS) contract and is commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are 9am to 6.30pm Monday to Friday. All appointments are walk-in. The 'out of hours' services are provided by an alternative provider, however the GPs carry out evening visits to local hostels.

The practice provides a wide range of medical services for homeless people and has an expertise in the primary care management of substance misuse, alcohol abuse and chronic severe mental illness. The Doctor Hickey Surgery has been providing services to homeless people in Westminster for thirty years.

In the last year the practice has provided a range of teaching opportunities related to homeless healthcare including: teaching sessions for General Practice trainees on a vocational training scheme; training for a nurse prescribing course being followed by one of the specialist homeless nurses in the local Homeless Health Team; training for pharmacist prescribing courses being followed by a local pharmacist with a particular interest in substance misuse; and a teaching project for medical students, led by the practice's regular locum to provide unique experience of the medical problems of homeless people.

Good

Are services safe?

Our findings

We rated the practice, and four of the population groups, as good for providing safe services. We did not rate two population groups: older people, as the number of patients in this group was low; and Families, children and young people, as the practice did not provide services to this group.

Safety systems and processes

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

- The practice had a suite of safety policies including adult and child safeguarding policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- Most patients at the practice were homeless and as such were regarded as vulnerable patients. However, there was a risk register specifically for vulnerable patients who experienced poor mental health.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. In response to action we said the provider should take at our inspection of May 2015, all staff who acted as chaperones were trained for the role, and had received a DBS check.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was an effective system to manage infection prevention and control.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. However, the practice recognised that they needed to update their infection control policy to include assessment of patients with presumed sepsis and raise awareness among the reception team of symptoms that might be reported by patients and how to respond.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.

Good

Are services safe?

- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. On the day our inspection we found checks of the oxygen cylinder supply were not recorded. However, immediately after the inspection the practice provided evidence that they had updated their equipment policy and introduced paperwork to enable such checks to be recorded monthly. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues, including risk assessments in each patient's records, which they had been involved in drafting. They were classified as low, medium or high risk depending on whether they had been violent in the past or more recently. Health and Safety risk assessments were formerly arranged by the building landlords but they had devolved this responsibility to the practice. An updated risk assessment was due and the practice acknowledged at the inspection they needed to arrange this as a priority. Immediately after the inspection, the practice confirmed that contact had been made with two independent companies with a view to arranging a comprehensive risk assessment.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were well established systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, we saw there had been an incident where needles had been found in a sanitary bin by a contractor when emptying the bin. The practice produced improved signage for display on the bins emphasising the dangers of needlestick injuries and where needles can be disposed of safely. Staff were asked to remain vigilant to avoid a recurrence of such incidents.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice and four of the population groups as good for providing effective services overall. We did not rate two population groups: older people, as the number of patients in this group was low; and Families, children and young people, as the practice did not provide services to this group

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Due to the nature of the practice they had relatively few older people using the service. There were 12 people over the age of 75 years registered at the time of our inspection, which was 0.5% of the practice population. Several of these were resident in a long stay homeless hostel which specialised in caring for women with severe mental illness. A senior partner GP from the practice attended the hostel every month to provide general medical care and physical health checks.
- As the number of patients in this group was low we did not rate this population group.

People with long-term conditions:

- The practice had identified that the key long-term conditions which most affected their patients were substance misuse and alcohol misuse.
- The GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care for these patients, who had complex needs.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- QOF performance for long term conditions was mostly above average. However, for asthma for 2016/17 it was below average (87% compared to the CCG average of 97% and national average of 97%). However, the practice explained that it was difficult to engage with such a transient group as the homeless population in consistent asthma treatment and attendance for review and this impacted on QOF achievement.

Families, children and young people:

- The practice was for homeless people and did not provide any services for families, children and young people. Where they found young people or families who were sleeping rough they would refer them to appropriate organisations to meet their health and social needs.

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

- The majority of the practice's patients were of working age, although relatively few of them were employed.
- The practice's uptake for cervical screening was 29%, which was significantly below the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening was significantly below the national average.
- Patients had access to appropriate health assessments and checks. All new patients received a comprehensive 'homeless person's medical check-up'. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

We discussed with the practice the relatively low uptake for national screening. The practice's advanced nurse practitioner proactively promoted cervical screening amongst the practice's female patients and all new patients were offered screening as part of the initial medical check-up. In the last 12 months the practice had achieved a 49% uptake rate, based on unpublished practice held data. The practice recognised that this was still relatively low but stressed this represented a very substantial improvement over previous years. The practice told us it actively

encouraged patients to participate in breast and bowel screening, including referral to the breast screening programme as part of the initial new patient medical check-up. However, there were difficulties in securing participation, given the transient nature of the practice's homeless population and the attitude of many of them towards health promotion and prevention.

People whose circumstances make them vulnerable:

Most patients at the practice were homeless and as such would fall into this category. However, the practice recognised that even within a homeless population, there are people of special vulnerability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- As most patients at the practice were homeless and as such were regarded as vulnerable patients, the practice did not hold a general register of patients living in vulnerable circumstances.
- However, there was a learning disability register and all patients on this register are invited to attend for an annual health check, provided by either a doctor or a nurse practitioner. Any health concerns arising are dealt with immediately in consultation. Of the eight patients on the register, seven (88%) had attended for a check in the last year.

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

A register of patients who experienced poor mental health was kept and these patients were invited in for three monthly reviews. Reception staff we spoke with were aware of signs to recognise for patients in crisis and would ensure they were urgently assessed by a GP if they presented at the practice.

- Because the practice had few elderly people, they had a low prevalence of dementia. The majority of those with dementia had chronic alcoholic brain syndromes and were considered among alcohol problem drinkers.

  However,100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the national average of 84%.
- 94% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 91% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average of 91%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Monitoring care and treatment

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

One of the key indicators against which the practice monitored effectiveness was impact on mortality rates. The practice believed that they have been able to add years to patients' lives based primarily from a comparison of their patients' average age at death with standard figures available in medical research literature. They have kept a record of all known deaths in their patient population since the inception of their existing primary medical services (PMS) contract on 1st August 2005. They have therefore been able to calculate the average age of death of their patients from that time until now as follows:

General Population:

77 years - 74 years (male) 80 years (female)

General homeless population:

47 years - 48 years (male) 43 years (female)

Practice Patients:

53 years - 54 years (male) 51 years (female)

Good

Are services effective?

(for example, treatment is effective)

When the practice started collecting data on mortality rates in 2005 the average age at death of its patients was 44 years.

The most recent published QOF results were 94% of the total number of points available compared with the clinical commissioning group (CCG) average of 90% and national average of 96%. The overall exception reporting rate was 30% compared with a national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The overall exception rate and the exception rates for the majority of clinical indicators were significantly higher than the CCG and national averages.
- QOF results were significantly below CCG and national averages for depression at 71% compared to 84% and 93% respectively.
- The high exception rates and below average OOF achievement for depression reflected the transient nature of the homeless population and the difficulty in securing their engagement with follow up care and treatment.
- The practice was actively involved in quality improvement activity. For example, there was an ongoing programme of clinical audit and we saw examples of completed two cycle audits including: the management of Hepatitis C; the prescribing of vitamins for people with alcohol problem drinking to prevent chronic alcohol brain syndromes; and the frequency of urine drugs screens in patients who are receiving long-term substance misuse treatment with methadone or buprenorphine in primary care.). The urine drug screen audit was undertaken to test achievement of the practice's policy that all patients receiving opiate substitution treatment should have urine drug screens at intervals of a maximum of three months. The audit found 88% achievement of the policy between February 2017 and January 2018 (against a target of 90%), compared to 91% achievement in the previous year. As a result of these findings, to secure improvement the practice implemented a more systematic way of auditing performance in this area on a weekly basis, using a new CCG model of 'Integrated Performance Reporting' (designed to monitor performance against plans to address selected health priorities).
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, the development of an Intermediary Care Network (ICN) to improve healthcare of homeless people who require additional healthcare support short of hospital admission; and participation in a London wide review of Homeless Health Services.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. The advanced nurse practitioner told us it was not always possible to take time out for training during the working day due to increasing patient demand. However, the practice anticipated that this would be addressed by the planned appointment of a health care assistant to support the nurse. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

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

Good

Are services effective?

(for example, treatment is effective)

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

Helping patients to live healthier lives

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

- As part of an ongoing health promotion plan, the practice took part in week-long health promotion events in which participants were offered opportunities to participate in a wide variety of health promotion activities, including cardiovascular screening (pulse, blood pressure), spirometry, near patient testing (glucose, cholesterol and blood-borne viruses), substance misuse engagement and also the opportunity for GP registration and consultation. GPs told us they found these very valuable ways of engaging hard to reach people within day centres, hostels and community centres.
- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and those requiring support in other areas such as benefits and/or housing. Patients were then signposted to the relevant service. A housing advice worker, benefits advisor and peer advocates from a charity were available on the premises. Patients in need of extra support were also referred to outreach substance dependency services or family planning.
- Staff encouraged and supported patients to be involved in monitoring and managing their health and discussed changes to care or treatment with them.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Outstanding ☆

Are services caring?

Our findings

We rated the practice, and four of the population groups, as outstanding for caring. We did not rate two population groups: older people, as the number of patients in this group was low; and Families, children and young people, as the practice did not provide services to this group.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- We observed throughout the inspection that staff treated patients with courtesy and were very patient and helpful towards them.
- Staff understood patients' personal, cultural, social and religious needs and were on first name terms with many of them.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The majority of the 37 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.
- The practice placed considerable importance on providing a positive waiting room experience for patients. The practice had entered into a partnership with a local food business who provided sandwiches daily for their patients. Patients we spoke with told us they especially welcomed this hospitality and the hot drinks provided at the practice.
- Patients were also provided with vouchers funded by a local community health charitable trust to obtain 'Health and Wellbeing Packs' to meet the most immediate needs of rough sleepers. The packs contained items including food vouchers, basic clothing, toiletries, sleeping bags, dental and podiatry hygiene packs, wellbeing and local services information, and simple medicines, including analgesics and vitamins for patients.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Of 364 surveys sent out 15 were returned. This represented about 0.7% of the practice population. It was difficult to draw meaningful conclusions from such a small number of responses. However, the practice was above average or comparable to other practices for several of its satisfaction scores on consultations with GPs and nurses. For example;

- 100% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 100% of patients who responded said the GP gave them enough time; CCG - 80%; national average - 86%.
- 100% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 93%; national average - 95%.
- 95% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 80%; national average - 86%.
- 85% of patients who responded said the nurse was good at listening to them; (CCG) - 86%; national average - 91%
- 89% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 85%; national average - 91%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care:

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Staff also made use of google translate. Information cards were available in different languages including Polish, Romanian and Spanish.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. Sign language services were available on the reception TV screen and the practice administrator was 'Makaton' trained to help communicate with patients with learning difficulties.
- Staff helped patients find further information and access community and advocacy services. They helped them ask questions about their care and treatment. For example, the practice participated in a Homeless Health Peer Advocacy project commissioned by Central London CCG which aims to help improve the health of

currently homeless people - primarily through charity based peer advocates offering one to one support to help access health services by accompanying people to appointments. Advocates all have personal experience of homelessness and two trained advocates were based at the practice.
- None of the patients registered at the practice were carers.
- The practice's in-house counsellor provided bereavement counselling to patients. Notices in the patient waiting room told patients how to access a number of support groups and organisations.

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

- 96% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 83% and the national average of 86%.
- 100% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 78%; national average - 82%.
- 100% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 85%; national average - 90%.
- 84% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 78%; national average - 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The CQC comments cards we received and the patients we spoke with confirmed that staff treated patients compassionately and did their utmost to provide them with the support they needed.
- Conversations with receptionists could not be overheard by patients in the waiting room.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and four of the population groups, as outstanding for providing responsive services. We did not rate two population groups: older people, as the number of patients in this group was low; and Families, children and young people, as the practice did not provide services to this group.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient's individual needs and preferences which were central to the delivery of tailored services and provision of person-centred care that involved other service providers, particularly for people with multiple and complex needs.

- The practice understood the needs of its population, people who were homeless or living in precarious accommodation, and tailored services in response to those needs. The practice told us there were approximately 1140 rough sleepers recorded in Westminster. Patients registered with the practice needed treatment, care and support mainly for substance misuse, alcohol dependency and mental health conditions.
- The practice used information about care and treatment to make improvements. For example, as of October 2017, the practice increased weekly medical sessions from 18 to 23 to offer five additional bookable sessions focusing on alcohol and substance misuse issues. This included additional nurse time which enabled the practice to respond much more quickly to new patients attending for registration, especially those seeking substance misuse treatment.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, there was a hearing loop at reception. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- Due to the nature of the practice they had relatively few older people using the service. There were 12 people over the age of 75 years registered at the time of our inspection, which was 0.5% of the practice population. Several of these were resident in a long stay homeless hostel which specialised in caring for women with severe mental illness. A senior partner GP from the practice attended the hostel every month to provide general medical care and physical health checks.
- As the number of patients in this group was low we did not rate this population group.

People with long-term conditions:

The practice had identified that the key long-term conditions which most affected their patients were substance misuse and alcohol misuse.

- Because substance misuse was a major cause of mortality and morbidity among homeless people, the practice had long had a special interest in this area. At the time of our inspection they had 325 patients being prescribed opiate substitutes. The practice understood they were the largest single primary care provider of opiate substitute therapy in Westminster. All these patients had a named GP and a structured three-monthly review to check that their health and medication needs were being met. Patients were referred to specialist substance misuse services and the in-house drug and alcohol counsellor.
- The practice recognised that alcohol problem drinking was an extremely significant condition amongst their local homeless population. They were continually seeking effective ways of engaging those patients in regular long-term treatment; therefore, they were engaged with Westminster City Council and Central London CCG to increase their 'in-reach' work into local alcohol hostels and 'outreach' work to the streets to provide general medical services to those patients.

Families, children and young people:

- The practice was for homeless people and did not provide any services for families, children and young

people. Where they found young people or families who were sleeping rough they would refer them to appropriate organisations to meet their health and social needs.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and where possible offered continuity of care. For example, extended opening hours.
- The majority of the practice's patients were of working age, although relatively few of them were employed. However, the practice recognised that many of them, especially recent migrants, saw work as their major route out of poverty and the practice team saw their role as helping their patients to become healthy enough to work. They had formed ongoing partnerships with training and work finding organisations including local charities, Westminster University and Job Centre Plus. They provided support at the practice to assist those patients who wished to become "job ready" by providing either training or work finding opportunities. For example, English language lessons, Construction Skills Certification Scheme cards, Cooking and IT Qualifications.

People whose circumstances make them vulnerable:

- The practice provided medical outreach to growing numbers of rough sleepers in Westminster. They ran a Street Doctor Program which was a medical outreach project where GPs and practice staff along with the City Council outreach teams would carry out a weekly session of night walks through the local streets and parks. They spoke with rough sleepers, identified their medical needs and addressed those needs in ways which were likely to improve both their general health and their ability to utilize general homelessness services, with the ultimate aim of permanent resettlement.
- The practice regarded entrenched rough sleepers, people who have been rough sleeping for a long time, usually because of major psychoses, as especially vulnerable. They required prolonged and patient engagement, which the practice provided in association with the City Council specialist outreach service for entrenched rough sleepers.
- The practice had developed a Hepatitis C bespoke clinic as this condition was common amongst homeless people and a cause of preventable death. This was originally being run as a pilot project when we inspected the practice in 2015. The pilot successfully demonstrated that engaging the population in which the disease is most prevalent is a highly effective and cost-efficient way of enabling access to treatment for those who need it the most. Central London CCG therefore agreed to include this service permanently in the contracting round from 2017 onwards as 'business as usual'.
- The practice kept a register of patients who were homeless military veterans and had a close working relationship with a veterans charity who they supported in providing services to this group. The charity referred many veterans to the practice for primary medical care and treatment.
- The practice also provided services for "failed" asylum seekers and undocumented migrants as they were frequently referred to the practice due to their reputation for ease of access.
- The practice had found that returning expatriates were an emerging high need population group amongst their patients. They often returned seeking medical treatment after many years overseas to find they have lost entitlement to social services and secondary health care under the "habitual residence test".

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

- The practice had an exceptionally high prevalence of patients with severe mental illness and personality disorder. They had entered into partnership with Primary Care Plus, a service which places psychiatric nurses and doctors in general practices to increase their engagement with people with mental health problems who are unable or unwilling to engage in traditional secondary care services. Under these arrangements, the practice had seconded to them a community psychiatric nurse (CPN) for two days a week; a homeless specialist psychotherapist; and a general counsellor for one day a week. Clinical staff would refer patients to these specialists as appropriate.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that they were able to access appointments when they needed them.
- The practice was open from 9am to 6.30pm Monday to Friday, but they were closed to patients between 12.30 and 2pm. The GPs made home visits to the local homeless hostels every evening to carry out physical health checks and medication reviews for people in the hostels who were either reluctant or too unwell to visit the surgery. The telephones were manned from 9am to 6pm daily. Appointments could not be booked in advance except to see the counsellors, as the practice offered a walk-in facility every day.
- Although GPs tried to accord to appointment times, they told us it was difficult due to their population group, which often resulted in patients having to wait a long time to be seen. The practice had responded to this concern by providing an 'access clinic' for quick access for relatively small and routine matters, such as repeat prescriptions, medical certificates and clinical letters. Patients could be slotted in by receptionists into the first available clinician, to minimise waiting times for these relatively quick matters. The practice told us these arrangements had been successful in minimising waiting times.
- Patients told us they were satisfied with the appointments system at the walk-in clinic. They said they had always been able to see a clinician the same day.
- 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 of the local walk-in centre specifically for homeless people and NHS 111 service.
- The practice's patient participation group had a website that gave information about services provided including appointments, home visits and repeat prescriptions.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to and often above local and national averages. Of 364 surveys sent out 15 were returned. This represented about 0.7% of the practice population. It was difficult to draw meaningful conclusions from such a small number of responses. However, the response to most of the questions was supported by observations on the day of inspection and completed comment cards.

- 84% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 100% of patients who responded said they could get through easily to the practice by phone; CCG – 83%; national average - 71%.
- 89% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 84%; national average - 84%.
- 88% of patients who responded said their last appointment was convenient; CCG - 76%; national average - 81%.
- 89% of patients who responded described their experience of making an appointment as good; CCG - 71%; national average - 73%.
- 47% of patients who responded said they don't normally have to wait too long to be seen; CCG - 53%; national average - 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Two complaints were received in the last year. We reviewed both complaints and found that they were satisfactorily handled in a timely way. At the time of our inspection one of the complaints was awaiting a final response from the complainant.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice and four of the population groups as outstanding for providing a well-led service. We did not rate two population groups: older people, as the number of patients in this group was low; and Families, children and young people, as the practice did not provide services to this group.

Leadership capacity and capability

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

- Leaders had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- They had a deep understanding of issues, challenges and priorities relating to the quality and future of services. They were addressing the challenges to improve service delivery.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice vision was set out in mission statement which was displayed in the waiting areas. The practice vision was that 'homeless people, whose health needs are so immense, should receive a standard of general practice at least equitable with that which the rest of the nation takes for granted'.
- The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

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

- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The continuing development of staff skills and knowledge was recognised as integral to ensure high quality care. There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out,

Are services well-led?

Outstanding ☆

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

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- One GP partner was on the board of the Clinical Commissioning Group (CCG) and was the chair of the Local Medical Committee (LMC) and was involved in planning and delivering services to meet the needs of their specific patient population. We saw that information from both these forums were fed back to practice staff at monthly practice meetings.

Managing risks, issues and performance

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

- There was a demonstrated commitment to best practice performance and risk management. There were systems and processes to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice maintained a comprehensive corporate risk register and all patients had risk assessments in their records which were classified as low, medium or high depending on whether they had been violent in the past or more recently. In addition, the practice had undertaken a detailed analysis of strengths, weaknesses, opportunities and threats (SWOT) to aid future risk management and planning.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- Services were developed with the participation of a full and diverse range of patients', staff and external partners. For example. the patient participation group; the Joint Strategic Needs Assessment; commissioned patient surveys; written comments received at the practice; internet comments via NHS Choices; the NHS Friends and Family Test; and National GP Patient survey. Their views and concerns were encouraged, heard and acted on to shape services and culture.

Are services well-led?

Outstanding ☆

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

- The patient participation group was initially very active but at the time of our inspection had been through a period of inactivity due to a number of issues. However, the former chair had agreed to stand again and was in the process of re-establishing the group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- The practice reviewed how it functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.
- There was a focus on continuous learning and improvement at all levels within the practice. For example. the practice carried out an audit of the performance of its in-house Hepatitis C clinic the practice and introduced two changes to overcome identified barriers to patient access to the treatment process: from 28 February 2018 offering dry spot blood testing (where blood samples are blotted and dried on filter paper) for patients with difficult venal access; and from April 2018 offering a fortnightly on-site consultant hepatologist clinic for patients with difficult engagement with secondary services.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. There was an annual staff awayday to support this.