York Street Health Practice

Quality Report

68 York Street
Leeds LS9 8AA
Tel: 0113 2954840
Website: www.leedscommunityhealthcare.nhs.uk

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at York Street Health Practice on 20 October 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised. Six monthly thematic reviews of reported incidents were undertaken and actions identified to minimise reoccurrence.
- All staff attended a daily 'huddle' meeting to discuss any issues which had arisen in the 24 hours preceding the meeting and to review and action any outstanding issues. We saw evidence of minutes from meetings and an up-to-date and ongoing action log.
- There were comprehensive safeguarding systems in place to enable staff to identify any areas of concern, act upon them in a timely manner and protect patients and staff from abuse. All clinical staff had formal safeguarding supervision with a member of the local safeguarding team on a regular basis.
- The practice actively reviewed complaints and how they were managed and responded to. There was open access to the practice manager where complaints could be dealt with as they arose.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients' emotional and social needs were seen as equally important as their physical needs. Patients said they were treated with compassion, dignity and respect.
- There was wide-ranging evidence of multi-agency working, where the practice worked closely with other organisations, such as outreach services, refugee councils and homeless shelters, in ensuring services were provided to meet patients' needs. We received numerous extremely positive testimonials to support this.

Summary of findings

- The practice had regular liaison with the Home Office and refugee camps to ensure there was a cohesive approach and the refugee/asylum seekers had timely access to care and support.
- The practice had strong and visible leadership and governance arrangements in place. Staff said felt very supported by management and the team as a whole and there were supportive mechanisms in place. All staff had access to a psychologist once a month and counselling sessions were available as needed. Staff were supported to attend mindfulness courses.
- There was 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.

We saw several areas of outstanding practice including:

- There were comprehensive systems in place to support safe practice. The whole team was engaged in reviewing and improving safety and safeguarding systems. The review of all incidents and the learning which arose from those was shared with their provider and external agencies, depending on the appropriateness and confidentiality aspects. There was an ongoing 'RAG rated' action plan used to capture and ensure all issues or status reports were discussed or actioned at all meetings. (RAG is a system based on Red, Amber and Green colours used to rate issues.)
- Staff were motivated and inspired to offer kind and compassionate care. For example, they provided suitable clothing for children and adults, food parcels, Christmas gifts, paid for transport for patients to attend appointments and raised money to aid patients as needed. The practice had won several awards for the delivery of compassionate care. Most recently, as part of the Pathway Group of organisations who provide services for homeless people, they had recently received the '2016 Kate Granger award for delivering outstanding compassionate care'.
- The practice delivered weekly outreach sessions for the homeless. Twice a month clinicians worked through the night, to provide access to health care and support for street sex workers.

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.

- Risk management was comprehensive, well embedded and recognised as being the responsibility of all staff.
- The whole team were engaged in reviewing and improving safety and safeguarding systems. All events were discussed at the daily 'huddle', weekly practice meetings and the monthly clinical meetings.
- The practice used every opportunity to learn from incidents and to support improvement. Learning was based on thorough analysis and investigation. The practice could evidence changes which had been made as a result.
- Six monthly thematic reviews of reported incidents were undertaken and actions identified to minimise reoccurrence. For example, there had been three immunisation errors, which had been discussed with staff and a review of the process undertaken. This had resulted in significant improvements.
- There was an ongoing RAG rated action plan used to ensure all issues or status reports were discussed or actioned at all meetings.
- The practice undertook individual case reviews of unexpected deaths of patients.
- The review of all incidents and the learning which arose from those was shared with their provider Leeds Community Health Care Trust. Relevant learning was also shared with external agencies, such as secondary care services, the Home Office, refugee councils or homeless workers; depending on the appropriateness and confidentiality aspects.
- There was a daily 'sign in and out' board so everyone knew where individual staff were, for example if they were participating in outreach services or visiting a patient.
- All clinical staff had safeguarding supervision with a member of the local safeguarding team on a regular basis.
- There were comprehensive systems in place and regular audits undertaken with regard to medicines management and the prescribing of opioids (potentially addictive pain relief medicines).

Are services effective?

Good ●

The practice is rated as good for providing effective services.

Summary of findings

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We saw evidence where these were discussed at meetings and an ongoing log was kept to audit what actions had been taken in response to new guidance.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. For example, following guidance relating to liver cirrhosis in the over 16s, the practice had identified patients who may be at risk and had reviewed the management of their care to ensure all appropriate patients were referred for treatment accordingly.
- The practice were proactive and worked with other local providers to understand and meet the range and complexity of patients' needs. For example, the practice had organised access to a number of bed spaces in a local homeless shelter.
- The practice undertook a programme of clinical audits which were relevant to their patient population and could demonstrate quality improvements.
- The practice employed a full time mental health nurse who provided intensive support for patients. As a result of their interventions and the use of a comprehensive mental health assessment, the practice could evidence a 26% reduction in anti-depressant prescribing and improved wellbeing of some patients.
- There was continuing development of staff skills and competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to work collaboratively and share best practice.
- All the GPs participated in a six monthly internal appraisal system, which they found to be a supportive process.
- All staff had annual appraisals and access to other development and support networks.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Staff were motivated and inspired to offer kind and compassionate care. For example, they provided suitable clothing for children and adults, food parcels, Christmas gifts, paid for transport for patients to attend appointments and raised money to aid patients as needed.

Summary of findings

- Patients' emotional and social needs were seen as important as their physical needs. We heard many examples from patients and external agencies to support this.
- Patients told us that if they did not have a permanent address they were able to use the postal address of the practice to stay in touch with their families and other agencies. We saw evidence to support this.
- Patients said they were treated with compassion, dignity and respect. We observed staff treat patients in a respectful, kind and caring manner. Patients were greeted by name and staff were aware of their personal circumstances and were able to offer support and assistance to individuals.
- We spoke with several professionals who worked alongside the practice and received many written testimonials from others. All comments were extremely positive about how caring staff at York Street Health Practice were.
- The practice had won several awards for the delivery of compassionate care. These included being the first GP practice nationally to receive the 2015 City of Sanctuary Health Stream Award (which recognises the important role played by the health services in the lives and well being of asylum seekers). As part of the Pathway Group of organisations who provide services for homeless people, they had recently received the '2016 Kate Granger award for delivering outstanding compassionate care'. (This award was to individuals, teams and organisations who demonstrated outstanding care for their patients.)
- The practice worked closely with palliative care services to support end of life care for patients and to find an appropriate setting for that care to be delivered to those who were homeless.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- The practice responded to the complex needs of patients in a timely and appropriate way. The mental health nurse offered consultations in areas away from the practice where the patient felt more comfortable and was more likely to attend the appointment.
- The practice delivered weekly outreach sessions for the homeless. Twice a month clinicians worked through the night, to provide access to health care and support for street sex workers.

Summary of findings

- There was daily liaison with the local hospital and accident and emergency department to identify any people who were homeless and unregistered with a GP and to support cohesive discharge planning.
- Vaccination catch up programmes were delivered for all new arrivals into the country who had incomplete vaccination histories.
- There was dedicated time to process the registration of UNHCR (United Nations High Commissioner for Refugees) arrivals. This allowed the registration of the whole family at a time that was suitable and caused as little stress as possible. We were told of several instances where the practice had liaised directly with the refugee camp to ensure urgent care was provided for patients upon their arrival into the country.
- There were ring fenced appointments for patients who were identified by other agencies as needing timely access to care and treatment, such as newly arrived refugees.
- Patients' comments we received indicated they found it easy to make an appointment with a clinician, there were open access appointments. Urgent cases were dealt with when needed.
- Staff regularly liaised with a homeless shelter in Leeds and ensured people staying there received medical care and support as needed.
- There was a separate waiting area for families with small children or for patients who were distressed.
- There was wide-ranging evidence of multi-agency working, where the practice worked closely with other organisations, such as outreach services, refugee councils and homeless shelters, in ensuring services were provided to meet patients' needs.

Are services well-led?

Good

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

- There was 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.
- The practice had strong and visible clinical and governance arrangements in place. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. There was a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and shared information with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.
- Staff said they felt very supported by management and the team as a whole. We were informed of the supportive mechanisms in place; staff had access to a psychologist once a month, counselling sessions were available as needed and staff had attended mindfulness courses.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- Compared to other practices, they had a small number of registered patients who were over the age of 65 years. However, proactive, responsive and personalised care was provided to meet the needs of these patients.
- Reviews of care were undertaken and any concerns were discussed at the daily 'huddle'.
- The practice worked with other agencies, such as outreach and homeless services, to support the needs of these patients
- In liaison with the local palliative care team, end of life care was provided for individuals as needed.
- Influenza and pneumococcal vaccinations were offered to everyone in this population group.

People with long term conditions

Good

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

- We were informed that many of the patients were not always in a position to manage their long term conditions until some stability had been achieved in their lives. Health advice and support was given by all clinicians to patients, taking into account their individual life circumstances. Patients had personalised care planning suitable to their needs.
- Patients at the practice presented with high levels of lung, liver and kidney disease. These could be linked to issues such as poor diet, alcohol and drug misuse. Staff had specific competencies in these areas and were able to support patients accordingly.
- There was an experienced nursing team who provided specialist wound care for venous ulcerations.
- Blood borne virus screening was undertaken. The practice had good liaison with the viral hepatology teams to improvement engagement of patients for Hepatitis C treatment.

Families, children and young people

Good

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

Summary of findings

- The practice currently had 61 patients who were under the age of 18 years. This population group fluctuated dependant on the numbers of UNHCR refugees allocated to the practice. It was acknowledged that this group of patients were particularly vulnerable.
- There were clear systems in place to identify and follow up children and families living in disadvantaged circumstances and who were at risk. For example, those females at risk of female genital mutilation (FGM) or human trafficking.
- There was a child safeguarding lead and a process in place to review all patient records for those aged under 18, in order to highlight and act on any safeguarding issues.
- There was a named health visitor attached to the practice to ensure continuity of care for families and young children.
- There was a separate waiting area for families with small children or for patients who were distressed.

Working age people (including those recently retired and students)

Good

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

- Over 90% of patients were noted to be of working age but there was a very high unemployment rate. This group included the homeless, asylum seekers and refugees.
- Flexible services were provided for these patients. For example, outreach services were provided on the streets, both during the day and night to enable patients to access clinicians.
- The practice supported people who were sleeping rough and could offer them temporary shelter through dedicated beds they had at a charitable homeless hostel based in Leeds centre.
- Patients were provided with flexible care and support to meet their individual needs. Health promotion and screening were offered opportunistically.

People whose circumstances may make them vulnerable

Outstanding

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, gypsy travellers and those with a learning disability.
- The practice offered longer appointments for patients who needed them.

Summary of findings

- The practice worked consistently, proactively and sensitively with multidisciplinary teams and other agencies, such refugee councils, homeless charities and poverty services, in the case management of vulnerable patients.
- Through their outreach sessions, the clinicians provided support and care in areas where homeless people were known to gather.
- Those people who were identified as being vulnerable and who were not registered with a GP were referred to York Street Health Practice by other agencies.
- The practice worked closely with local substance misuse services to support patients to access treatments as befitted their needs.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. They had a comprehensive understanding of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Staff had attended training sessions on FGM awareness and trafficking. They could demonstrate a good understanding and awareness of how to approach those at risk. There was evidence of working alongside other agencies to identify and support those patients as befit their needs.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

- The practice had no known patients who had dementia, however, they had high levels of patients who experienced mental ill health or psychological distress and treated them as appropriate.
- Staff had a good understanding of how to support patients with mental health needs and consistently worked with multidisciplinary teams in the case management of these patients. They also worked closely with teams providing support through counselling and psychological therapies.
- Patients were actively assisted to access various support groups and organisations, including social and housing support.
- The practice employed a full time mental health nurse who had professional experience of working with patients who had complex needs. They arranged to see those patients who were most likely to not attend an appointment, outside of the practice environment, such as a coffee shop, to support their health needs.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health or were vulnerable. These patients were discussed in the daily 'huddle' meetings and care plans updated.

Summary of findings

What people who use the service say

The national GP patient survey (published in July 2016) distributed 338 survey forms of which 35 were returned. This was a response rate of 10% which represented less than 3% of the practice patient list. The results showed that for the majority of questions, the respondent satisfaction levels were below the local clinical commissioning group (CCG) and national averages. The lower than normal responses may be reflective of the demographics and transient nature of the practice population group. For example:

- 75% of respondents described their overall experience of the practice as fairly or very good (CCG 82%, national 85%)
- 64% of respondents said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG 76%, national 79%)
- 63% of respondents described their experience of making an appointment as good (CCG 70%, national 73%)
- 94% of respondents said they found the receptionists at the practice helpful (CCG 85%, national 87%)
- 87% of respondents said they had confidence and trust in the last GP they saw or spoke to (CCG 94%, national 95%)
- 90% of respondents said they had confidence and trust in the last nurse they saw or spoke to (CCG 96%, national 97%)

However, patients' comments we received on the day were consistently positive.

The most recent Friends and Family Test results showed that 100% of patients would recommend the practice.

As part of our inspection we asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 13 comment cards, 12 of which were all positive about accessibility to the service and the standard of care received. Many said the service was 'essential' in supporting the needs of homeless people. They cited staff as being 'extremely helpful', courteous, caring and professional. Only one card was negative saying they 'were not happy to queue'.

We spoke with three patients on the day, who were all very positive about the service and care they received. They gave us several examples to highlight how they had been helped by staff to sort out some of the complex issues they encountered. Patients told us how they had been treated in a professional, non-judgemental and caring manner and that they had trust in the staff and felt relaxed in the practice environment. They said this was 'important to them'.

The general view of patients we received both from the comment cards and by speaking with them, was that they felt valued and respected as individuals by all the staff.

We also spoke with several professionals who worked alongside the practice and received many written testimonials from others. All comments were extremely positive about the work York Street Health Practice were doing and how they worked collaboratively to support better outcomes for patients or help them to be safe on the streets.

Outstanding practice

- There were comprehensive systems in place to support safe practice. The whole team was engaged in reviewing and improving safety and safeguarding systems. The review of all incidents and the learning which arose from those was shared with their provider and external agencies, depending on the appropriateness and confidentiality aspects. There was an ongoing 'RAG rated' action plan used to capture and ensure all issues or status reports were discussed or actioned at all meetings. (RAG is a system based on Red, Amber and Green colours used to rate issues.)
- Staff were motivated and inspired to offer kind and compassionate care. For example, they provided suitable clothing for children and adults, food parcels, Christmas gifts, paid for transport for patients to

Summary of findings

attend appointments and raised money to aid patients as needed. The practice had won several awards for the delivery of compassionate care. Most recently, as part of the Pathway Group of organisations who provide services for homeless people, they had recently received the '2016 Kate Granger award for delivering outstanding compassionate care'.

- The practice delivered weekly outreach sessions for the homeless. Twice a month clinicians worked through the night, to provide access to health care and support for street sex workers.

York Street Health Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser and a second CQC inspector.

Background to York Street Health Practice

York Street Health Practice is a member of Leeds South and East Clinical Commissioning Group. The provider of the service is Leeds Community Healthcare Trust (LCHT). Alternative Provider Medical Services (APMS) are provided under a contract with NHS England. This is a locally negotiated contract which allows NHS England to contract services from non-NHS bodies. The practice are also a member of Pathway (a UK homeless healthcare charity); a group of organisations who specifically work with and support people who are homeless.

The practice does not participate in the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK, which financially rewards practices for the management of some of the most common long term conditions.) However, the practice has its own Key Performance Indicators (KPIs) which are submitted on a quarterly and annual basis to their provider LCHT.

The practice provides a range of primary care services for:

- homeless people
- people in temporary or unstable accommodation
- refugees or those seeking asylum
- street-based sex workers
- people who find it hard to access the health care and support they need due to chaotic and complex lifestyles

The staff worked closely with other organisations and with the local community in ensuring bespoke services are provided to meet patients' needs. The Homeless Admissions Leeds Pathway (HALP) is operated under York Street Health Practice in partnership with St George's Crypt Homeless Hostel (a charity in the centre of Leeds who work with the homeless and vulnerable and can provide intermediate care beds). The practice had negotiated to have access to three beds there where patients who are in urgent need can be sent.

Patients are often referred to the practice by other agencies or identified through hospital admissions, prison release or word of mouth. In addition, those people seeking asylum status or refugees are also registered. The practice has close links with refugee camps in Syria and the identification of those refugees who are suitable to arrive in Leeds is undertaken in conjunction with the Home Office.

At the time of inspection there were 1,315 patients registered with York Street Health Practice (1,083 male and 232 female). Due to the transient nature of this patient group the practice experiences a high turnover of registered patients, with 15 to 20 new registrations per week. Over 61% of the patient population are homeless and 31% are asylum seekers/refugees. The majority of patients are in the 26 to 65 years age range; with 4% under 18 years of age, 13% aged between 18 and 25 and 1% aged over 65. There is a mixed ethnicity of patients, including white British, African, Asian and Syrian.

The practice is open from 8.30am to 6pm on Monday, Tuesday and Friday. On Wednesday and Thursday the opening times are 9am to 5pm. Patients can access appointments and clinicians during these times. The practice is closed daily between 1.30pm and 2pm to enable all staff to attend a daily meeting known as the 'huddle'. In

addition, there is open access to clinicians and patients can be seen outside of the practice as befit their needs. When the practice is closed the telephones are directed to local care direct. We were informed that due to restrictions in their provider contract, they were unable to offer extended hours access. However, outreach and night services are operated, where clinicians engage with members in the community, such as the homeless or sex workers, who may or may not be registered with the practice.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations, such as NHS England and Leeds South and East CCG, to share what they knew about the practice. We reviewed the latest national GP patient survey results (July 2016). We also reviewed policies, procedures and other relevant information the practice provided before and during the day of inspection.

We carried out an announced inspection on 20 October 2016. During our visit we:

- Spoke with a range of staff, which included three GPs, a clinical lead nurse, a practice nurse, a mental health nurse and a health care assistant. We also spoke with the practice manager and the administration manager.
- We reviewed questionnaires sent to staff prior to the inspection.
- Reviewed CQC comment cards and spoke with patients regarding the care they received and their opinion of the practice.
- Observed in the reception area how patients, carers and family members were treated.
- Looked at templates and information the practice used to deliver patient care and treatment plans.
- Spoke with other organisations who work alongside York Street Health Practice in supporting patients.
- Attended the daily 'huddle' as an observer.

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

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

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

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

Please note that when referring to information throughout this report, this relates to the most recent information available to the CQC at that time.

Outstanding ☆

Are services safe?

Our findings

Safe track record and learning

The practice had a systematic and comprehensive approach for reporting, recording and acting upon significant events. There was good analysis of incidents and evidence that changes had been made as a result. There was a genuinely open culture in which all safety concerns raised by staff and people who used the services were highly valued as integral to learning and improvement.

- When reporting an incident, staff told us they would complete the electronic recording form, which was available on the practice computer system, and would also verbally inform the practice manager.
- The whole team were engaged in reviewing and improving safety and safeguarding systems. All events were discussed at the daily 'huddle', weekly practice meetings and the monthly clinical meetings.
- In addition, 'panel' meetings were also held where incidents or safeguarding risks to patients could be discussed on an individual basis. We saw evidence of formal minutes which identified the incident, relevant information, actions and by whom.
- The practice had an ongoing RAG rating (auditable) action plan used to ensure all issues or status reports were discussed or actioned at all meetings.
- We saw evidence that six monthly thematic reviews were undertaken and actions had been taken to minimise reoccurrence. For example, in the preceding six months it had been noted there had been several prescribing errors. This had been discussed in the clinical team meeting and a review of the systems undertaken. An evaluation of any improvements as a result was to be undertaken at the next thematic review in March 2017.
- The practice had seen an increase in incidents where patients had been aggressive or violent. Staff were actively encouraged to report all incidents to ensure procedures were being followed in those instances.
- The practice undertook individual case reviews of deaths of patients. This was to identify whether any were unexpected, there were any themes, or any preventative work which could have helped and any learning arising from these.
- The review of all incidents and the learning which arose from those was shared with their provider Leeds Community Health Care Trust. Relevant learning was also shared with external agencies, such as secondary care services, the Home Office, refugee councils or homeless workers, depending on the appropriateness and confidentiality aspects.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. Lessons were shared and action was taken to improve safety in the practice. For example, it had been noted there had been an error in resetting the vaccine fridge temperature. The medicines management team had been contacted for advice regarding the vaccines. There had been a review of records to ensure that patients had not been affected. There had also been retraining of staff.

Overview of safety systems and processes

There were comprehensive, clearly defined and embedded systems, processes and practices in place to keep patients and staff safe and safeguarded from abuse. We saw evidence of:

- Arrangements, which reflected current legislation and local requirements, were in place to safeguard children and vulnerable adults from abuse. Policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. We saw posters displayed in the reception area and consulting rooms, advising patients and staff of what safeguarding is, what to do if there were any concerns and who to contact. There were separate clinical leads for adult safeguarding and children's safeguarding. The practice had strong links with the local safeguarding authority and reports for case conferences were provided where necessary. There was a process in place to review all patients' records for those aged 18 and under, in order to highlight any safeguarding issues. All clinical staff had safeguarding supervision with a member of the local safeguarding team on a regular basis. In addition to issues being discussed at the daily 'huddle' meeting, quarterly dedicated safeguarding meetings were held. The practice had a good working relationship with the named health visitor, who they regularly discussed any child safeguarding issues or concerns with. All the GPs and nursing staff were trained to level three safeguarding and non-clinical staff were trained to level two. There was evidence of staff attending additional training, such as awareness of FGM and human

trafficking. All staff could demonstrate a good understanding of safeguarding and gave us numerous examples where concerns in respect of patients had been raised and actioned.

- Notices advising that a chaperone was available if required were displayed in all patients' areas throughout the practice and were in a variety of languages suitable to the patients' countries of origin. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS). (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.)
- Appropriately maintained standards of cleanliness and hygiene in the practice. There was a comprehensive cleaning schedule in place, which was adhered to. There was a clinical lead for infection prevention and control (IPC) who liaised with the provider's IPC team. They attended IPC meetings and kept up to date with best practice. There was an IPC policy in place and all staff had received up to date IPC training. Annual IPC audits were undertaken and we evidence that action was taken to address any identified improvements.
- Safe and effective arrangements for medicines management, which included obtaining, prescribing, recording, handling, storing, security and the disposal of medicines within the practice. There were safe processes and standard operating procedures for handling repeat prescriptions which included the review of high risk medicines. We were informed of the comprehensive procedures in place for the initial and repeat prescribing of opioid medication, such as methadone; which was used in the treatment of heroin addiction. The practice could evidence a clear audit trail of the prescription forms used for methadone prescribing. This ensured there was safe prescribing and a minimised risk of patient misuse. All patients prescribed these medicines were reviewed between weekly and three monthly intervals as a maximum, depending on individual circumstances. Prescription pads and blank prescriptions were securely stored and there were systems in place to monitor their use.
- The practice carried out regular and thorough medicine audits to ensure prescribing was in line with current guidelines and to support positive patient outcomes. For example, antipsychotic monitoring and the prescribing of antidepressants to patients on methadone. We observed that action had been taken with regard to these audits, such as the reduction and eventual withdrawal of medication, under supervision, in specific patients.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines, in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment, in line with the practice recruitment policy. For example, qualifications, reference, proof of identification and DBS checks.

Monitoring risks to patients

Risks to patients were assessed and well managed. We saw evidence or procedures in place for monitoring and managing risks to patient and staff safety. For example:

- Health and safety risk assessments, such as the control of substances hazardous to health, fire risk and legionella. (Legionella is a bacterium which can contaminate water systems in buildings.) There were processes in place to check that all electrical and clinical equipment was in good working order and safe to use. We checked a sample of equipment and found them to have been tested and calibrated.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff worked flexibly to cover any changes in demand, for example annual leave, sickness or seasonal demands. There was a proactive approach to anticipating and managing risks to people who used the service. Staff rotas were discussed at the daily meeting. The practice planned when additional staff may be needed, for example when numbers of refugees from the camps were expected.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. We saw:

Outstanding ☆

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- There was a daily 'sign in and out' board so everyone knew where individual staff were, for example if they were participating in outreach services or visiting a patient. There was a comprehensive lone worker policy to support staff working outside of the practice premises.
- All staff were up to date with fire and basic life support training.
- There was a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were stored in a secure area which was easily accessible for staff. All the medicines and equipment we checked were in date and fit for use.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and was available on the practice intranet and as a paper copies.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We saw evidence that that guidance was a driving force behind many of the practice audits that were undertaken.

Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We saw evidence where these were discussed at the daily meetings and wider practice meetings. There was an ongoing log to audit what actions had been taken, or audits undertaken, in response to any new NICE guidance.

We also saw evidence to confirm that the practice used these guidelines to positively influence and improve clinical practise and outcomes for patients. For example, as a result of guidance issued relating to myocardial infarction (heart attack) an audit had been undertaken to identify that all newly diagnosed patients had a follow-up review with a clinician, a rehabilitation assessment and assessment of further risk. There had been five patients identified at the time and care management plans were put in place for all. The practice continued to review any new cases.

Management, monitoring and improving outcomes for people

The practice did not participate in the Quality and Outcomes Framework (QOF). However, the practice had its own Key Performance Indicators (KPIs) which were submitted on a quarterly and annual basis to their provider Leeds Community Healthcare Trust (LCHT). These were used by the provider to ensure the practice was performing in line with locally agreed objectives and outcomes. The practice provided evidence to support this. Information submitted regarding the KPIs related to delivering safe, person centred, multidisciplinary collaborative care for patients registered at the practice. These included access, right care right time, reduction in inappropriate bed stays, safe and cost effective prescribing.

In addition to CCG prescribing audits or external LCHT audits, the practice undertook a specific and continual programme of clinical audits which were relevant to their patient population and could demonstrate quality improvements. Findings were used by the practice to improve services. We looked at five completed audits, three of which were two cycle. These showed where improvements had been implemented, shared and monitored. For example, as a result of some published guidance, an audit had been undertaken regarding the prescribing of gabapentin and pregabalin (medicines used to treat seizures) in patients on methadone (medicine used in patients to assist withdrawal from heroin or other addictive drugs). An initial audit had shown there were 33 patients identified. These patients were supported to reduce their dosage with a view to stopping. A second audit showed that this number had reduced to 16. Findings showed that two had been initiated by the practice and 14 had been initiated elsewhere, such as secondary care services. After the initial audit a policy had been put in place stating the reduction and withdrawal process which would be undertaken with current and all new patients. All clinical staff were informed of the policy and patients were discussed at clinical meetings. There was a three monthly search undertaken of all appropriate patients. A third reaudit showed the practice were adhering 100% to the policy and there had been no new initiations made by the practice.

A mental health nurse was employed who provided intensive support for patients, including those patients who suffered from depression. There was a standard operating procedure in place that all patients received a comprehensive mental health assessment before commencing any treatment with antidepressants. In addition, all patients who were currently prescribed antidepressants (156) were reviewed and also supported to reduce their medication. As a result the practice could evidence a 26% reduction (40 patients) in the rates of antidepressant prescribing without a reported decrease in those patients' wellbeing.

There was continual auditing of antipsychotic prescribing and the monitoring of relevant patients. (Antipsychotics are medicines used in complex mental health cases such as schizophrenia and bipolar disorder.) All patients were

Good

Are services effective?

(for example, treatment is effective)

invited or seen opportunistically for reviews of their physical and psychological health. Some of these patients were seen through the outreach and night sessions undertaken by clinicians.

The practice informed us that due to the transient nature, ad hoc attendance and vulnerability of some patients, every opportunity and contact with their patients was used proactively. Staff provided health promotion and prevention, advice on how to keep safe on the streets and reviews of care and treatment plans.

Patients gave several examples where they had been supported to improve their health and wellbeing. For example, with the help of both the practice staff and a substance misuse worker a patient had successfully managed to stop taking drugs.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- There was continuing development of staff skills and competence and knowledge was recognised as integral to ensuring high quality care, this included mandatory training such as safeguarding and health and safety. Staff were encouraged and supported to attend any training which would improve care delivery for patients. For example, how to recognise signs of abuse or torture. Some nursing staff had undergone additional training in leg ulcer management. All staff had undergone conflict resolution training to assist them in managing difficult situations.
- Staff were proactively supported to work collaboratively and share best practice. The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring and clinical supervision.
- Staff who administered vaccines and took samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who could demonstrate how they stayed up to date with changes to the immunisation and screening programmes, by accessing online resources and discussion at practice meetings.
- All staff had annual appraisals and access to other development and support networks.
- All the GPs participated in a six monthly internal appraisal system, which they found to be a supportive process.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.

Staff worked with other health and social care services, voluntary groups, local charities for the homeless and refugee agencies, to understand and meet the complexity of patients' needs. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

We saw evidence that patients were discussed in the daily meeting, clinical and multidisciplinary meetings. Care plans were updated as necessary and sharing of information with other agencies was agreed in line with patient consent.

In addition, the practice undertook regular 'panel' meetings with multidisciplinary staff as needed. These meetings were ad hoc, based on when there was a need to urgently discuss issues regarding a patient, specifically those who were known to be aggressive or physically violent. We saw evidence of the minutes and actions taken. For example, in some instances the police had become involved.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, such as the Mental Capacity Act 2005. Patients' consent to care and treatment was sought in line with these. Where a patient's mental capacity to provide consent was unclear, the GP or nurse assessed this and, where appropriate, recorded the outcome of the assessment.

Good

Are services effective?

(for example, treatment is effective)

When providing care and treatment for children 16 years or younger, assessments of capacity to consent were also carried out in line with relevant guidance, such as Gillick competency and Fraser guidelines. These are used to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We saw evidence that when a patient gave consent it was recorded in their notes.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients with complex mental health needs, sex workers, homeless people, asylum seekers and refugees.

- We were informed that many of the patients were not always in a position to manage their health adequately until some stability had been achieved in their lives. Health advice and support was given by all clinicians to patients, taking into account their individual life circumstances.
- Patients had personalised care planning suitable to their needs and were signposted to other services as appropriate, such as housing benefit and care navigators.
- Blood borne virus screening was undertaken. The practice had good liaison with the viral hepatology teams to improvement the engagement of patients for Hepatitis C treatment.
- Influenza and pneumococcal vaccinations were offered to appropriate patients. There was a targeted outreach approach which also aimed to identify homeless patients or those vulnerable patients not already registered with a GP practice.
- There was an experienced nursing team who provided specialist wound care for venous ulcerations, which were frequent in homeless patients or those with substance misuse issues.
- Cervical screening was offered to eligible females and we saw evidence that 113 patients had attended for smears during the period November 2014 to October 2016. Due to the transient nature of the patients, it was not easy to establish the exact numbers of patients who would have been eligible during that period. The practice also acknowledged that some patients did not have a fixed address which could make recall difficult.
- Most children who were registered at the practice were refugees/asylum seekers and often arrived with incomplete vaccination histories. Vaccinations were provided in line with the national childhood immunisation programme. At the time of inspection there were 49 under 16 year olds registered; 37 of whom were up to date with their immunisation programme, one was a newborn baby and 21 were new arrivals and had incomplete histories and were commenced onto the programme.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that:

- There was a private room should patients in the reception area want to discuss sensitive issues or appeared distressed.
- Curtains were provided in consulting and treatment rooms to maintain the patient's dignity during examinations, investigations and treatment.
- Doors to consulting and treatment rooms were closed during patient consultations and that we could not hear any conversations that may have been taking place.
- Chaperones were available for those patients who requested one.

Results from the national GP patient survey showed respondents rated the practice below CCG and national averages. The data below is based on 35 responses received, which was a response rate of 10% and less than 3% of the practice patient list. The lower than normal response rate may be reflective of the demographics of this practice's patient population. However, these results did not align with what patients told us on the day of inspection. For example:

- 76% of respondents said the last GP they saw or spoke to was good at listening to them (CCG 87%, national 89%)
- 74% of respondents said the last GP they saw or spoke to was good at giving them enough time (CCG 85%, national 87%)
- 78% of respondents said the last GP they spoke to was good at treating them with care and concern (CCG 82%, national 85%)
- 74% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG and national 91%)
- 80% of respondents said the last nurse they saw or spoke to was good at giving them enough time (CCG and national 92%)
- 72% of respondents said the last nurse they spoke to was good at treating them with care and concern (CCG 90%, national 91%)

We received 13 CQC comment cards, 12 of which were all positive about accessibility to the service and the standard of care received. Only one card was less positive saying they "were not happy to queue". Many said the service was "essential in supporting the needs of homeless people". They cited staff as being "fantastic" and felt they were treated with dignity and respect. There were several examples where patients said they felt care and support provided by staff had been "over and above" and a "life saver".

We spoke with three patients on the day, who were all very positive about the service and care they received. They gave us several examples to highlight how they had been helped by staff to sort out some of the complex issues they encountered. Also how they had been treated in a professional, non-judgemental and caring manner. Patients told us they felt they could trust the staff, felt relaxed in the practice environment and how important it was to them.

During the inspection feedback from patients about their care and treatment was consistently and strongly positively. We observed a strong patient-centred culture and one where patients were obviously comfortable speaking with staff. We saw and heard staff speaking to patients on a first name basis, providing reassurance and giving general health and wellbeing advice to those patients. We were informed of many positive examples to demonstrate how staff cared for and responded to patients above and beyond expectations. For example, the provision of suitable clothing for children and adults, food parcels, Christmas gifts and the raising of money to aid patients as needed. A patient we spoke with told us how a member of staff had given them a hat to keep their head warm, and how appreciative they had been of this simple gesture. Patients also told us how they had been supported to find housing and how to manage from a practical aspect. We also heard where patients no longer registered at the practice would attend and inform staff how they were managing and the changes they had helped them to make.

We also spoke with several professionals who worked alongside the practice and received many written testimonials from others. All comments were extremely positive about the work York Street Health Practice were doing and how they worked collaboratively to support better outcomes for patients.

The practice had won several awards for the delivery of compassionate care. These included being the first GP practice nationally to receive the 2015 City of Sanctuary Health Stream Award (which recognises the important role

played by the health services in the lives and wellbeing of asylum seekers). As part of the Pathway Group, they had also recently received the '2016 Kate Granger award for delivering outstanding compassionate care'. (This award was to individuals, teams and organisations who demonstrated outstanding care for their patients.)

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

However, results from the national GP patient survey showed respondents rated the practice below CCG and national practices, for some of the questions. The data below is based on 35 responses received, which was a response rate of 10% and less than 3% of the practice patient list. The lower than normal response rate may be reflective of the demographics of this practice's patient population. However, these results did not align with what patients told us on the day of inspection. For example:

- 65% of respondents said the last GP they saw was good at involving them in decisions about their care (CCG 80%, national 82%)
- 75% of respondents said the last GP they saw was good at explaining tests and treatments (CCG 84%, national 86%)
- 76% of respondents said the last nurse they saw was good at involving them in decisions about their care (CCG 84%, national 85%)
- 85% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 89%, national 90%)

Staff told us that interpretation and translation services were available for patients who did not have English as a first language. There was information provided in the practice to inform patients of this service and staff arranged interpreters as necessary.

There was a multitude of leaflets available in several languages suitable to patients' country of origin. There were dedicated time slots for patients who were refugees or asylum seekers, to give them the time and support to be involved in decisions about their care. We also saw that care plans were personalised to take into account the complex needs of individuals.

Patient and carer support to cope emotionally with care and treatment

Leaflets and notices were available in the practice which told patients how to access a number of support groups and organisations. For example, support for mental health, domestic abuse, substance misuse, sexual health, homeless services. Patients gave us several examples where they felt they had been extremely well supported by practice staff during an emotional and distressing time. Some patients had been rehoused in areas outside of the practice. However, due to the complexity of some of those patients, the practice had kept them on their patient list to maintain continuity of care or until stability in their circumstances was embedded.

We were informed that if a patient was a carer it would be identified on their patient record. Written information was available to direct carers to the various avenues of support available to them. We were informed that due to the transient nature of the patient population there were very few patients who said they had a carer. If a patient had a next of kin or an identified support worker this would be recorded in their record.

The practice liaised with a Leeds based charity which provided psychotherapy, complementary therapies and advocacy support to the survivors of persecution and exile, many of whom have been traumatised by inhumane atrocities. Feedback from patients was extremely positive.

Staff worked closely with palliative care services to support end of life care for patients and to find an appropriate setting for that care to be delivered to those who were homeless. Support, or signposting to relevant services, was offered for those families who had experienced bereavement.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with their provider and other local agencies to secure improvements to services. Practice staff worked closely with other organisations and with the local community in ensuring bespoke services were provided to meet patients' needs. These agencies included Leeds based charities who dealt with the homeless and those who experienced substance misuse; refugee organisations, poverty services, gypsy traveller services and other Leeds outreach services. The practice had integrated pathways with some of these agencies, to aid responsive care and support for patients.

Patients were often referred to the practice by other agencies or identified through hospital admissions, prison release or word of mouth. In addition, those people seeking asylum status or refugees were also registered at the practice. The practice had developed close links with refugee camps in Syria and worked in conjunction with the Home Office to ensure refugees were safely registered with the practice. These patients were eventually discharged from the service when they were housed outside of the area. However, each patient was dealt with on a case by case basis, dependant on their individual needs and ability to integrate effectively into mainstream services. This had resulted in some patients remaining with the practice longer to maintain continuity of care.

The practice worked collaboratively with UNHCR regarding those refugees who were allocated to the practice. It was acknowledged that this group of patients were particularly vulnerable; consequently there was dedicated time to process the registration of those patients. This allowed the registration of the whole family at a time that was suitable to their needs to cause as little additional stress as possible. We were told of several instances where the practice had liaised directly with the refugee camp to ensure urgent care was provided for patients upon their arrival into the country. For example, a patient who had been identified as having cancer whilst they were in a refugee camp. The practice had organised urgent access to care and treatment upon their entry into the UK. They had then subsequently supported the patient as appropriate.

Appointments were offered based on the needs of the patient. For example, a longer appointment had been arranged for a patient who was non-English speaking and also had hearing and speech impairments. Interpreters and sign language personnel were organised at a time suitable for the patient. Some members of staff were multilingual and could support the translation of information for patients as needed.

Before vulnerable patients were discharged from hospital, a clinician would liaise with ward staff and review the personal and social circumstances of the patient, such as whether they had a home to go to. This supported effective discharge planning and having an appropriate aftercare management plan in place. The practice would then liaise with other services as necessary, for example in finding suitable accommodation. They also had a number of dedicated bed spaces at a local homeless shelter where the practice could support patients if they were requiring additional medical support.

Patients had access to a mental health nurse who had professional experience of working with patients who were homeless, had substance misuse or mental health issues; specifically personality disorders.

There was an experienced and specialist trained nurse who was employed by the practice in ensuring that patients received comprehensive sexual health services and advice. Staff had attended training sessions on FGM and trafficking. They could demonstrate a good understanding and awareness of how to approach those at risk. There was evidence of working alongside other agencies to support those patients.

Therapeutic, physiotherapy and advisory services were available at the practice for patients to access.

The practice participated in local health and wellbeing events, such as the 'men's health week' during which they had engaged with 102 participants.

Access to the service

The practice was open from 8.30am to 6pm on Monday, Tuesday and Friday. On Wednesday and Thursday the opening times were 9am to 5pm. Patients could access appointments and clinicians during these times. However,

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

the practice was closed daily between 1.30pm and 2pm to enable all staff to attend a daily meeting known as the 'huddle'. When the practice was closed the telephones were directed to local care direct.

There were 15 minute appointments as standard, however, there was flexibility dependant on the need of the patient. Appointments were pre-bookable, book on the day and there were also 'open access' appointments with the clinicians and therapists based at the practice.

There were ring fenced appointments for patients who were identified by other agencies, such as those supporting the homeless, as needing access to care and treatment. In addition, weekly outreach sessions were provided for homeless patients from 5am in a morning. Clinicians also worked through the night twice a month, to provide access to health care and support for street sex workers. A review of demand and capacity was regularly undertaken and also discussed at the daily meeting and practice meetings. We saw evidence of the ongoing logs to support this.

Results from the national GP patient survey showed respondents satisfaction rates regarding access were variable compared to CCG and national averages. The data below was based on 35 responses received, which was a response rate of 10% and less than 3% of the practice patient list. The lower than normal response rate may be reflective of the demographics of this practice's patient population. For example:

- 67% of respondents were fairly or very satisfied with the practice opening hours (CCG 77%, national 78%)
- 69% of respondents said they could get through easily to the surgery by phone (CCG 68%, national 73%)
- However, 100% of respondents said the last appointment they got was convenient (CCG 91%, national 92%)

Patients' comments we received on the day told us they were able to get appointments when they needed them. We were given several examples where the practice had 'fitted' them in or seen them urgently.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

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

We saw there had been no complaints received in the preceding 12 months. However, there was evidence the practice reviewed survey responses and comments made by patients in general. For example, some patients had commented they felt others were being seen before them. This had related to refugee/asylum seeker patients who had dedicated time slots to reduce anxiety for those patients. As a result staff informed patients as appropriate. In addition, the practice manager had dedicated time where patients could speak with them to share any concerns, comments or thoughts. This was advertised in the waiting room and promoted by staff. Patients we spoke with told us they would speak with the practice manager or a member of staff if they had an issue. The practice manager kept a log of any issues raised by patients and these were discussed in the daily meeting. However, we were informed that many of the patients "just wanted to chat".

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision which had quality care 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. Staff were clear about the vision and told us they were inspired and motivated to achieve it.

Their mission statement and values were "to be dedicated to providing healthcare that meets the needs of people who were homeless, vulnerable, refugees or seeking asylum in Leeds". There was a collaborative approach to working in partnership with other agencies that could support the social wellbeing of patients and help the practice to improve care outcomes.

Governance arrangements

The practice had strong and visible clinical and governance arrangements in place. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The practice had:

- A clear staffing structure in which all staff were aware of their own roles and responsibilities.
- Embedded policies in place which were available to all staff.
- A programme of continuous clinical and internal audit used to monitor quality and to make improvements.
- Comprehensive systems in place for identifying, recording and managing risks, issues and implementing mitigating actions.
- A system in place where all actions arising from meetings, significant events or any identified risks, were on a 'RAG rated' continuous action plan, which was easily accessible for staff and also provided a clear audit trail.

Leadership and culture

On the day of inspection the practice as a whole, demonstrated they had the experience, capacity and capability to ensure high quality care was provided for patients. We were informed they prioritised safe and compassionate care. There was a high level of strong collaboration with other agencies and support for all staff in having a common focus on improving quality of care and patient experiences.

The practice had been nominated for and won several awards over the preceding two years for the delivery of compassionate care. These included being the first GP practice nationally to receive the 2015 City of Sanctuary Health Stream Award (which recognises the important role played by the health services in the lives and well being of asylum seekers). In addition, the nursing team had won an award for support to primary care and the practice manager had been awarded an Honorary Doctorate for their work with the homeless.

All staff had a visible presence in the practice and were approachable. We were informed that the managers were available and took the time to listen to staff. There were regular meetings, including the daily 'huddle', which all staff attended and were supported to raise any issues, discuss any concerns and share experiences and learning. Staff informed us there was an open culture within the practice and they felt respected, valued and supported. There were supportive mechanisms in place; staff had access to a psychologist once a month, counselling sessions were available as needed and staff had access to mindfulness courses, of which many had attended.

We were informed there was a strong culture of openness and honesty. This was supported by the systematic and comprehensive approach we saw for the reporting, recording and acting upon significants. The practice was aware of, and had systems in place to ensure compliance with, the requirements of the duty of candour. When there were unexpected or unintended incidents regarding care and treatment, the patients affected were given reasonable support, truthful information and a verbal and written apology.

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

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

- Patients through day to day engagement with them.
- The NHS Friends and Family Test (FFT), complaints and compliments received.

Are services well-led?

Good

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

- Staff, through meetings, discussions and the appraisal process. Staff told us they would not hesitate to raise any concerns and felt involved and engaged within the practice to improve service delivery and outcomes for patients.
- Other agencies and organisations the practice worked collaboratively with.
- Despite the complex nature of patients, the practice had managed to develop a patient participation group, although it was in its infancy stages. We saw minutes of a recent meeting held in September, where feedback was provided from the patients. Generally, patients felt they had access to clinicians, the receptionists were always helpful. However, they felt the building itself was too small for the numbers of patients registered.

Continuous improvement

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

The practice consistently and tirelessly worked with other agencies to ensure those patients with complex needs were supported appropriately. For example, working with a local charity organisation in Leeds in the provision of temporary beds for homeless people and ensuring they received timely medical care and treatment. Also working with a refugee council to ensure new arrivals were registered and supported before moving onto mainstream services.