The Doctor Hickey Surgery

Quality Report

The Cardinal Hume Centre
3 Arneway Street
London SW1P 2BG
Tel: 020 7222 8593
Website:

Date of inspection visit: 7 May 2015
Date of publication: 19/11/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9
Outstanding practice	9

Detailed findings from this inspection

Our inspection team	10
Background to The Doctor Hickey Surgery	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Doctor Hickey Surgery on 7 May 2015. Overall the practice is rated as outstanding.

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

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. Opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place,

Summary of findings

was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice had a Street Doctor Program which was a medical outreach project where GPs and some practice staff 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 utilize general homelessness services, with the ultimate aim of permanent resettlement.
- The practice employed an in-house drug and alcohol counsellor who was available five days a week and a general counsellor one day a week. They would see both booked and walk-in patients. They would see up to nine patients a day.
- 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 this was sometimes the only food they ate for days.

However there were areas of practice where the provider should make improvements:

- The practice should ensure chaperone training is undertaken for all members of staff who perform these duties.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. We observed a patient-centred culture. Patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and appointments were always available on the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. It had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using a number of external agencies, and it had a very active patient participation group (PPG) which influenced practice development.

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

Due to the nature of the practice they had relatively few older people using the service. There were 15 people over the age of 75 years registered at the time of our inspection, which was 0.8% of the practice population. Most of these were resident in a long stay homeless hostel which specialised in caring for women with severe mental illness. One GP from the practice attended the hostel every month to provide general medical care and physical health checks.

As the amount of patients in this group was low we did not rate this population group.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of 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.

The practice had recognised that substance misuse was a major cause of mortality and morbidity among homeless people and at the time of our inspection they had 283 patients being prescribed opiate substitutes. As such 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 GPs had recognised that alcohol problem drinking was an extremely significant condition amongst their local homeless population; therefore they were providing general medical services in the local alcohol hostels.

Families, children and young people

Not sufficient evidence to rate

The practice was for homeless people and did not provide any services for families, children and young people. Where they found young people who were sleeping rough they would refer them to appropriate charities.

Summary of findings

Working age people (including those recently retired and students) The majority of the practice patients were of working age, although relatively few of them were employed. However, the GPs recognised that work was the major route out of poverty for some of their patients and they saw their role as helping their patients to become healthy enough to work. They had also formed partnerships with charitable organisations and Westminster University who 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.	**Outstanding**
People whose circumstances may 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 especial 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 The GPs provided medical outreach to entrenched 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 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 had developed a hepatitis C bespoke clinic as this condition was common amongst homeless people and a cause of preventable death. 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".	**Outstanding**
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	**Outstanding**

Summary of findings

into partnership with Primary Care Plus, a new 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. The practice had a consultant psychiatrist based at the practice one day per week. They also had a Community Psychiatric Nurse (CPN) based there two days a week whose role was to support patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. GPs would refer patients to the consultant psychiatrist, CPN or refer them to Improving Access to Psychological Therapy (IAPT).

The practice also employed an in-house counsellor who was based at the practice one day a week. They provided general counselling for patients including Cognitive Behavioural Therapy and bereavement counselling. A register of patients who experienced poor mental health was kept and these patients were invited in for three monthly reviews. Seventy six per cent of patients in this group had been reviewed in the last three months. 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.

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection and received 30 completed Care Quality

Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were very positive about the practice.

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff and felt the practice had saved their life. They said staff were friendly, considerate and understanding and the GPs gave consistently good care and went over and above their role as doctors

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure chaperone training is undertaken for all members of staff who perform these duties

Outstanding practice

- The practice had a Street Doctor Program which was a medical outreach project where GPs and some practice staff 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 utilize general homelessness services, with the ultimate aim of permanent resettlement.
- The practice employed an in-house drug and alcohol counsellor who was available five days a week and a general counsellor one day a week. They would see both booked and walk-in patients. They would see up to nine patients a day.
- 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 this was sometimes the only food they ate for days.

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, who was accompanied by a GP who was granted the same authority to enter the practice premises as the CQC inspector.

Background to The Doctor Hickey Surgery

The Doctor Hickey Surgery provides GP primary care services to approximately 1,700 homeless people in Westminster. The practice is staffed by three GPs, two male and one female who work a combination of full and part time hours. The practice employs one nurse, a counsellor, a practice manager and four administrative staff. 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 details of the 'out of hours' service were communicated in a recorded message accessed by calling the practice when it was closed. 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.

There about 6,000 rough sleepers recorded last year in England. More than half of those were in London and about a third are in Westminster where the Doctor Hickey Surgery has been providing services for twenty seven years.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

- Older people
- People with long term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Detailed findings

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 7 May 2015. During our visit we spoke with a range of staff (doctors, nurse, practice manager, counsellor and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. Administrative staff and receptionists told us they would inform the practice manager and log any significant event or incident. We saw there were two templates available on the practice computer, one for administrative incidents and one for clinical incidents. These were usually discussed on the day they occurred and always discussed at the weekly governance meeting. We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw that where there had been an incident where an object was thrown at a GP all objects of that nature were removed from the practice. All staff were informed and patients were advised of the change and why.

The practice carried out an analysis of the significant events (SEA) annually which included identifying any learning from the incidents and produced an annual report which detailed any themes.

National patient safety alerts were disseminated by the practice manager to the relevant practice staff by email through the practices computer system messaging facility. Staff we spoke with told us of recent alerts they had discussed regarding a diabetic drug.

Reliable safety systems and processes including safeguarding

Arrangements were in place to safeguard adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient’s welfare. There was a lead member of staff for safeguarding. Staff had received training relevant to their role. They all knew how to recognise signs of abuse vulnerable adults. They were also aware of their responsibilities and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were displayed on the walls in the general office and the GP consulting rooms and on computer desktops. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone, administration staff had been asked to carry out this role. Although, we were told that chaperone training had not been undertaken by these staff members, all staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff with chaperone duties had been Disclosure and Barring Service checked.

Medicines management

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Medicines were stored in medicine refrigerators in the nurse’s treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw the nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

The GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings, for example the prescribing of Metoclopramide and Domperidone.

The practice had a repeat prescribing policy and patients on methadone were reviewed on a monthly basis.

Good

Are services safe?

The practice took part in monthly South Locality meetings with other GP practices in south Westminster, which periodically was attended by the CCG's Medicine Management Team who reported on prescribing levels at each practice.

Cleanliness and infection control

Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead for the clinical areas and the practice manager was the lead for all other areas. There was an infection control protocol in place and staff had received up to date training. Monthly infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

Cleaning records were kept which showed that all areas in the practice were cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers which showed tests had been carried out in April 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, nebulisers, spirometer and weighing scales.

Staffing and recruitment

Recruitment checks were carried out and the six files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The practice manager occasionally provided cover in reception during busy periods.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were required to read as part of their induction which was accessible on the intranet for all staff.

All patients had risk assessments in their 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.

The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There were also panic buttons under all desks which would be pressed if a patient presented an immediate serious risk. This alert was also heard by staff in the housing project upstairs who would also attend. All staff had received training on how to use these and staff we spoke with told us the panic button was pressed at least once a week. We saw these systems were tested weekly.

All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

Good

Are services safe?

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. We reviewed some clinical meeting minutes and confirmed that this occurred. For example, the practice had recently received a guideline on management of people with Chronic Obstructive Pulmonary Disease (COPD) and the practice had identified where improvements could be made to their spirometry testing for patients. Clinical staff we spoke with were open about asking for, and providing colleagues with, advice and support. We saw that where a clinician had concerns they would 'instant message' another clinician to get a second opinion.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In 2012/13 they had scored 92%, however in 2013/14 there were discrepancies regarding the register that have now been addressed and current results were 91% of the total number of points available, with 14.6% exception reporting.

The data from the practices QOF dashboard showed performance for diabetes related indicators was 97.5% which was 6.5% above the CCG and 1.4% above national average. The percentage of patients with hypertension having regular blood pressure tests and the dementia diagnosis rate was 100%, both of which were above the CCG and national averages.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been five clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, recent action taken in response to audit findings included increasing the amount of three monthly urine checks carried out for patients using long term opiate substitutes. After re-audit there were 88% of patients on long-term opiate substitution treatment having had a urine drug screen within the previous three months. This represents an improvement on last year where it was 60%. The GPs told us this was still inadequate as the audit standard (90%) which they had set was not achieved.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. We reviewed staff training records and saw that all staff had an induction programme which covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety. Staff also had to complete regular mandatory courses such as annual basic life support and defibrillator training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics. Staff also had access to additional training to ensure they had the knowledge and skills required to carry out their roles. For example, reception staff told us they had received information technology, conflict resolution and customer service training. However, chaperone training had not been undertaken by some staff members who performed this duty on occasions.

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 meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.

Coordinating patient care and information sharing

Good

Are services effective?

(for example, treatment is effective)

The GPs told us whatever gains they have achieved with their patients, were only achieved in collaboration with many other partners in secondary care. They said both the causes and consequences of homelessness are generally multi-factorial and usually involve a complex and rapidly changing matrix of social, physical, psychological and spiritual problems. It was beyond the competence of any single service or institution to demonstrate any kind of success. Therefore they saw referral and collaboration as central to their role as a General Practice for homeless people**.** We saw they were participating in the Central London GP network which was set up to deliver the Whole Systems Integrated Care (WSIC) pilot within the area of Central London CCG.

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 test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and were attended by community services, the City Council, voluntary and other health services. We saw that care plans were routinely reviewed and updated at these meetings.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

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 & 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 hostels and day centres. These events occurred in day centres, hostels and community centres.

Patients who may be in need of extra support were also identified by the practice. These included those 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 Groundswell (a charity, which exists to enable homeless and vulnerable people to take more control of their lives, have a greater influence on services and play a full role in their community) were available on the premises. Patients who were in need of extra support were identified by the practice and appropriately referred. For example to outreach substance dependency services or family planning.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 82% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

The percentage of patients aged over 6 months to under 65 years in the defined influenza clinical risk groups that received the seasonal influenza vaccination were 47% which was below the national average of 52%. The GPs told us they were continually trying to improve their flu vaccinations for their patients which had increased from 40% last year.

Patients had access to appropriate health assessments and checks. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 30 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with four members of the patient participation group (PPG) on the day of our inspection. They told us they were satisfied with the care provided and their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support over and above a normal GP practice. For example staff would visit them at hostels up to 10pm.

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 this was sometimes the only food they ate for days. They also provided sleeping bags for patients who were sleeping rough and mailboxes for patients to receive mail such as hospital appointments.

Due to the specific patient group the practice is not required to take place in national GP patient survey.

However, all the 10 patients we spoke with told us they felt the GPs and nurses were good at listening to them and gave them enough time. They said they had confidence and trust in all the staff and found the receptionists very helpful.

Care planning and involvement in decisions about care and treatment

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

We were told by staff that some patients did not speak English as their first language, therefore they would use a telephone translation service or google translate when needed. We saw that information cards were available in different languages such as Romanian, Polish and Spanish.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this feedback. For example, patients described how staff responded compassionately when they had been diagnosed with serious conditions and provided support when required.

The practice had an in-house counsellor who provided bereavement counselling to patients and notices in the patient waiting room told patients how to access a number of support groups and organisations.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to the needs of their patient population which were people who were homeless or living in precarious accommodation. The GPs told us that over the years the patient-profile has changed frequently, and often dramatically. They said it was dependent on what communities were in temporary accommodation in the local area. The practice told us there were approximately 2000 rough sleepers recorded in Westminster. We saw patients registered with the practice needed treatment, care and support mainly for substance misuse, alcohol dependency and mental health conditions.

One GP was on the board of the Clinical Commissioning Group (CCG) and was the chair of the Local Medical Committee (LMC) and is involved in planning and delivering services to meet the needs of their specific patient population. The practice attended a monthly village meeting with other practices, housing and social care organisations to discuss local needs and plan service improvements that needed to be prioritised. We saw minutes of meetings and saw topics discussed included avoidable A&E attendances and integrated care and support pathways.

The practice had recognised that substance misuse was a major cause of mortality and morbidity among homeless people and that the average age of death of an intravenous drug user in London was around 35. At the time of our inspection they had 283 patients being prescribed opiate substitutes. As such they were the largest single primary care provider of opiate substitute therapy in Westminster. All these patients had a named GP and structured three monthly reviews to check that their health and medication needs were being met. Patients were referred to specialist substance misuse services and their in-house drug and alcohol counsellor.

The practice also employed an in-house drug and alcohol counsellor who was available five days a week and would see both booked patients and walk-in patients. We saw they would see up to nine patients a day on occasions.

The GPs told us there was a well evidenced need for medical outreach to entrenched rough sleepers in London. They therefore ran a Street Doctor Program which was a medical outreach project where GPs and some practice staff would carry out night walks through the local 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. For example, we saw a person they had met in the park had attended the surgery the following day and had been treated for their presenting symptoms. However, once they had built up a relationship with the GP they had discovered the underlying cause and was then referred for appropriate treatment and medication. We saw evidence to confirm that due to this project rough sleepers had received both medical treatment and support to find accommodation.

All GPs had completed parts one of the Royal College for General Practitioners (RCGP) Substance Misuse certificate. The practice also had access to a counselling service which was situated in the same building where they could refer patients for drug and alcohol counselling.

The practice had developed a hepatitis C bespoke clinic as this condition was common amongst homeless people and a cause of preventable death. 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".

The practice had a primary care liaison nurse for mental health based at the practice two days a week and a consultant psychiatrist every Friday. Their role was to support patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. They would also see patients referred to them from the practice. We saw they would refer patients to Improving Access to Psychological Therapies (IAPT) or support patients themselves.

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

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

The premises were accessible to patients with disabilities. 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.

Access to the service

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 carried out home visits to the local homeless hostels every evening. They told us they carried 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 9.00am to 6.30pm daily. Appointments could not be booked in advance except to see the counsellors, as the practice offered a walk-in facility every day. We observed patient queuing before the doors opened on the day of our inspection, which the staff told us was a daily occurrence. Although GPs tried to stick 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. However, patients told us they were satisfied with the appointments system. 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 was in the process of setting up their website; however their patient participation group had a website that gave information about appointments, home visits and repeat prescriptions.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice

We looked at eight complaints received in the last twelve months and found these were dealt with in a timely way in line with the complaints policy. We saw that one theme had emerged which was long waiting times to see GPs. Appropriate apologies were given on the understanding that the practice would renew their efforts to reduce waiting times whilst still adhering to their open access philosophy.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. There was also information about how to contact other organisations such as NHS England to make a complaint displayed on the walls. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. 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 robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

All members of staff we spoke with knew and understood the vision and values

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice held monthly management update meetings which were attended by the partners, the practice manager. We looked at minutes from these meetings and found that performance, quality, training and accounts had been discussed.

One GP partner was on the board of the Clinical Commissioning Group (CCG) and was the chair of the Local Medical Committee (LMC). We saw that information from both these forums were fed back to practice staff at monthly practice meetings.

The practice had a comprehensive understanding of their performance. They attended a monthly peer review meeting with other practices and used the Quality and Outcomes Framework (QOF) to measure their performance, which showed it was performing above national standards. Staff told us QOF data was regularly reviewed and discussed at the practices monthly meetings.

There was a programme of continuous clinical and internal audit used to monitor quality and to make improvements. Further, there were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, 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.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed Staff told us that regular team meetings were held and that there was an open culture within the practice. They said they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. We also noted that team away days were held every 12 months. Staff said they felt respected, valued and supported, particularly by the partners in the practice. There were high levels of staff satisfaction Staff were proud of the organisation as a place to work and speak highly of the culture All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Practice seeks and acts on feedback from its patients, the public and staff

Innovative approaches were used to gather feedback from people who use services including people in different equality groups The GPs told us they had recognised that obtaining honest and objective feedback from their patients was particularly difficult. This was because homeless people were accustomed to telling people and institutions what they think those people and institutions wish to hear, despite whatever assurances that honest

responses were welcomed. They also felt patients were extremely loyal because of the unique service offered and because they were accustomed to poor services they were therefore excessively fault-tolerant.

The practice therefore sought the help of independent agencies using anonymised surveys such as housing needs analysis (HNA) who carried out a very comprehensive assessment of homeless people in Westminster. They have also used the charitable arm of Her Majesty's Revenue and Customs (HMRC) who performed an anonymous patient survey amongst their patient population. We saw they addressed both the strengths and weaknesses of the practice.

The key points for improvement included the need to reduce long waiting times whenever possible and increase capacity on a Monday morning as it was generally a busy time. The practice had identified it was the commonest time for new registrations, especially for people seeking substance misuse treatment. We saw the practice responded by allocating one additional session of medical and nursing time to Monday mornings, which meant there were two doctors working in parallel, one doing the 'walk-in' surgery and the other focusing on alcohol and substance misuse issues. The additional nurse time meant that the practice could respond much more quickly to new patients attending for registration, especially those seeking substance misuse treatment.

The practice had an active patient participation group (PPG) which met quarterly. Despite them facing particular challenges in engaging their particular population in a patient participation group, they told us they began slowly and gently with a specific consultation with regard to making changes in their provision to Hopkinson House (a homeless hostel where they provide services). As this went well they decided to engage the help of the PPG development officer at Central London CCG. They have now successfully recruited their first permanent PPG, which has elected officers and have set up a website to engage patients of the surgery. Members of the PPG told us they were in the process of setting up their first patient survey, but that they have been encouraging patients to complete the friends and family test.

The practice had also gathered feedback from staff through staff away days, staff meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, when staff had raised concerns about there only being one exit to use in the event of an incident taking place in the waiting area, the practice established an additional exit. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot scheme to improve outcomes for patients in the area. For example they were taking part in an Assertive Outreach' Project funded by an innovation grant from NHS Westminster which offered a more assertive medical and nursing response to high need patients, both on the streets and in homeless hostels.