The Greenhouse Practice

Quality Report

19 Tudor Rd
London
E9 7SN
Tel: 020 8510 4490
Website: www.thegreenhousegp.co.uk

Date of inspection visit: 15 June 2017
Date of publication: 18/08/2017

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?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Greenhouse Practice on 15 June 2017. Overall the practice is rated as outstanding.

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

- There was a strong, open and embedded culture at the practice in respect of patient safety and the practice used every opportunity to learn from incidents. We observed a genuine open culture in which all safety concerns raised by staff were highly valued and integral to learning and improvement. All staff were encouraged to participate in learning and to improve safety as much as possible. We saw evidence that incidents were shared externally to enhance learning on a wider basis.
- Comprehensive systems were in place to keep people safe, which took account of current best practice. For example, there was an effective system in place to review patients on high risk medicines which included a nominated lead, an alert on the clinical system, a recall system and regular patient audits to ensure prescribing was in line with safe and best practice.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- There was evidence of quality improvement including clinical audit. We saw that the practice had put in place a comprehensive audit programme which was driven by the needs of the practice population in order to improve patient outcomes. There had been 11 clinical audits commenced in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- Feedback from patients about their care was consistently positive. Data from the national GP patient survey showed patients rated the practice

Summary of findings

higher than others for almost all aspects of care. Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice worked closely with co-located housing officers and homelessness case workers to support patients transitioning into more secure accommodation.
- The practice worked with other care providers to reduce inequality and improve access to secondary and specialised care.
- Leaders had an inspiring shared purpose and a clear vision which had reducing inequality and access to high quality, safe care as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff and the Patient Association. There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvements:

- Continue to monitor practice performance in relation to outcomes for patients with long term conditions.
- Review and improve how patients with caring responsibilities are identified and recorded on the clinical system to ensure that information, advice and support is made available to them.
- The practice should review arrangements in place to ensure a patient has access to a female GP if this is requested.

We saw several areas of outstanding practice:

- The practice did not place a limit on the number of walk-in appointments available on any day so that patients who found it difficult to book appointments in advance or who struggled to adhere to scheduled appointments, could access GP services in a way that suited them.
- A specialist substance and alcohol misuse clinician at the practice offered and delivered alcohol and substance reduction programmes. The substance misuse clinician and the lead GP had a meeting before every clinical session and would discuss the care plan for each patient with an appointment. Patients attending this clinic who had not recently seen a GP were encouraged to see the doctor and would be accommodated on the same day where possible. This meant that GPs were able to undertake opportunistic health and medicine reviews.
- The practice had reviewed the practice list within the previous year and had identified an increasing number of Polish and Vietnamese speaking patients registering. The practice had arranged for a Vietnamese speaking interpreter from a local hospital to attend the practice weekly and had employed its own Polish speaking translator who also attended the practice one day per week. Patients we spoke with told us this had significantly improved their access to health services.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were comparable to the national average for most indicators. For instance, the percentage of patients on the diabetes register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 80% (CCG average 85%, national average 80%) whilst 95% had a record of a foot examination and risk classification (CCG average 92%, national average 88%).
- Staff were aware of current evidence based guidance.
- There had been 11 clinical audits commenced in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that 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 accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had arranged for Polish and Vietnamese speaking interpreters to visit the practice every week.
- The practice had made an arrangement with the operator of a chain of sandwich shops to provide a supply of healthy foods, including sandwiches and fruit, to the practice.
- The practice allowed patients to stay and socialise in the waiting area before and after appointments.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For instance, the practice did not place a limit on the number of walk-in appointments available on any day so that patients who found it difficult to book appointments in advance or who struggled to adhere to scheduled appointments, could access GP services in a way that suited them.
- The practice sent text messages to patients to remind them to attend appointments or to alert them when they were due to have a health or medicine review and had a protocol in place to mitigate the risk of contact details being out of date.
- The practice provided shower facilities for patients and offered free shower consumables, including towels, to patients who needed them.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice hosted additional services to help patients access specialised care locally. For instance, the practice hosted weekly sessions with a psychotherapist, diabetic nurse and a podiatrist.

Summary of findings

Are services well-led?

Outstanding 

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The management team encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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

There were no patients over the age of 75 registered with the practice, so we did not rate this aspect. It must be noted, however, that the practice demonstrated an awareness of the needs of patients over the age of 75.

Not sufficient evidence to rate

People with long term conditions

The practice is rated as good for providing effective and caring services and outstanding for providing safe, responsive and well led services. The practice is rated as outstanding for the care of people with long-term conditions.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients on the diabetes register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 80% (CCG average 85%, national average 80%) whilst 95% had a record of a foot examination and risk classification (CCG average 92%, national average 88%).
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Outstanding ☆

Families, children and young people

The practice is rated as good for providing effective and caring services and outstanding for providing safe, responsive and well led services. The practice is rated as outstanding for the care of families, children and young people.

- The practice did not register patients aged under 16 years and there were a very small number of patients aged under 18 years

Outstanding ☆

Summary of findings

of age registered with the practice. However, some patients at the practice had young family members who were cared for by other people and we noted that the practice demonstrated an awareness of the needs of families, children and young people.
- The practice had emergency processes for acutely ill young people and for acute pregnancy complications.
- Patients told us, on the day of inspection, that young people were treated in an age-appropriate way and were recognised as individuals.
- The practice's uptake for the cervical screening programme was 77%, which was comparable with the CCG average of 79% and the national average of 81%.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as good for providing effective and caring services and outstanding for providing safe, responsive and well led services. The practice is rated as outstanding for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, by offering unlimited walk-in appointments each weekday.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Many of the practice population could only access the practice website using mobile telephones so it had been designed to optimal when viewed on mobile devices.
- The practice provided a room for weekly clinics run by a social justice charity that advised patients about education, housing and legal advice.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as good for providing effective and caring services and outstanding for providing safe, responsive and well led services. The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

- The practice' computer system would alert staff to all of the outstanding care needs of patients who visiting the practice. This helped clinicians provide more effective care for patients who preferred to attend the practice infrequently.

Summary of findings

- A protocol had been put in place through which reception staff would check latest contact details with patients at every point of contact. This meant that the practice was able use an appointment text reminder service effectively.
- The practice had worked closely with the local palliative care team as well as local hospices to develop a strategy to support patients who were approaching the end of their lives. This support included helping patients to consider where they might prefer to die and whether they would like assistance with tracing or contacting family members. The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Staff displayed patience and compassion when speaking with patients who were distressed. Reception staff knew that if patients wanted to discuss sensitive issues they could offer them a private room to discuss their needs.
- The practice was aware that the nature of their population group meant that patients often had complex family backgrounds which could add to the distress experienced during times of bereavement. Staff were sensitive to this and would consider how to react to each bereavement on an individual basis. For instance, the practice told us they would try to find specialist support for patients who were estranged from their families or who needed emergency funding to attend a funeral.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as good for providing effective and caring services and outstanding for providing safe, responsive and well led services. The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 94% compared to the CCG average of 91% and national average of 89%. The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of eligible women with schizophrenia, bipolar affective disorder and other psychoses who had had a cervical screening test in the preceding 5 years was 94% (17 of 18 patients).

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above local and national averages. Three hundred and twenty nine survey forms were distributed and 28 were returned. This represented 3% of the practice's patient list.

- 96% of patients described the overall experience of this GP practice as good compared with the CCG average of 84% and the national average of 85%.
- 98% of patients described their experience of making an appointment as good (CCG average 73%, national average of 73%).
- 95% of patients said they would recommend this GP practice to someone who has just moved to the local area (CCG average 79%, national average of 80%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all positive about the standard of care received. People said the practice provided them with practical support and advice in addition to their physical health needs.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed, compassionate, patient and caring.

Areas for improvement

Action the service SHOULD take to improve

- Continue to monitor practice performance in relation to outcomes for patients with long term conditions.
- Review and improve how patients with caring responsibilities are identified and recorded on the clinical system to ensure that information, advice and support is made available to them.
- The practice should review arrangements in place to ensure a patient has access to a female GP if this is requested.

Outstanding practice

We saw several areas of outstanding practice:

- The practice did not place a limit on the number of walk-in appointments available on any day so that patients who found it difficult to book appointments in advance or who struggled to adhere to scheduled appointments, could access GP services in a way that suited them.
- A specialist substance and alcohol misuse clinician at the practice offered and delivered alcohol and substance reduction programmes. The substance misuse clinician and the lead GP had a meeting before every clinical session and would discuss the care plan for each patient with an appointment. Patients attending this clinic who had not recently seen a GP were encouraged to see the doctor and would be accommodated on the same day where possible. This meant that GPs were able to undertake opportunistic health and medicine reviews.
- The practice had reviewed the practice list within the previous year and had identified an increasing number of Polish and Vietnamese speaking patients registering. The practice had arranged for a Vietnamese speaking interpreter from a local hospital to attend the practice weekly and had employed its own Polish speaking translator who also attended the practice one day per week. Patients we spoke with told us this had significantly improved their access to health services.

The Greenhouse Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to The Greenhouse Practice

The Greenhouse Practice provides primary medical services to approximately 1,000 patients in the London Borough of Hackney and is one of 36 member practices in the NHS Hackney Clinical Commissioning Group (CCG). It is a specialist service providing GP services to street homeless people or those in temporary or hostel accommodation in the borough of Hackney. Forty percent of the practice population are rough sleepers whilst 60% live in hostels or other temporary accommodation. The practice does not register patients aged under 16 years.

The practice population is in the most deprived decile in England. Ninety-six percent of patients have at least one long-standing condition whilst 75% have three or more long standing conditions. Approximately 75% of the practice population is male and 25% are female. There are no patients aged over 75 years registered at the practice. The practice has surveyed the ethnicity of the practice population and has determined that 53% of patients identified as having white ethnicity, with significant population groups of British and Eastern European origin, 7% Caribbean, 10% as other black background 30% as having mixed or other ethnicity.

The practice operates from a purpose built property with all patient facilities being wheelchair accessible. There are offices for administrative and management staff on the ground and lower ground floors.

The practice operates under a caretaker contract with the NHS. This was awarded in April 2016 and is currently scheduled to end in 2018.

The practice team at the surgery is made up of one part-time male clinical lead GP, and two part time male GPs who provide a combined total of nine GP sessions. There is a part-time locum practice nurse nursing a part-time substance misuse clinician, and a healthcare assistant (HCA) who also undertakes reception duties. In addition, there are six further administrative staff including a full-time practice manager and a director of operations who also fulfils this role for other practices managed by the provider.

The practice is registered to provide the regulated activities of maternity and midwifery services, diagnostic and screening procedures, family planning and treatment of disease, disorder or injury.

Appointments with GPs are available every weekday morning between 8:30am and 11:50am, every afternoon between 2pm and 6:20pm. In addition to pre-bookable appointments that can be booked up to four weeks in advance, urgent appointments are also available for patients that need them. The practice did not have a limit on how many walk-in appointments were offered in a day.

The practice has opted not to provide out of hours services (OOH) to patients and these were provided on the practice's behalf by City & Hackney Urgent Healthcare Social Enterprise (CHUSE). The details of the how to access the OOH service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website.

Detailed findings

Patients can book appointments in person, on-line or by telephone. Patients can access a range of appointments with the GPs and nurses. Face to face appointments are available on the day and are also bookable up to four weeks in advance. Telephone consultations are offered where advice and prescriptions, if appropriate, can be issued and a telephone triage system is in operation where a patient's condition is assessed and clinical advice given. Home visits are offered to patients whose condition means they cannot visit the practice.

The practice hosts a wide range of services including clinics for diabetes, respiratory conditions and psychological support. The practice also provides health promotion services including a flu vaccination programme and cervical screening.

The Greenhouse Practice has not previously been inspected by CQC.

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 we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 June 2017. During our visit we:

- Spoke with a range of staff (GP, locum nurse, practice manager, Director of Operations, Substance Misuse Clinician and members of the reception and administration team) and spoke with patients who used the service.
- Spoke with external agencies (local authority housing officer, homelessness charity case worker) with whom the practice works closely to support patients.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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:

- people with long-term conditions
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia)

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.

Outstanding ☆

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of three documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events
- We saw evidence that lessons were shared and action was taken to improve safety in the practice and that lessons learnt were shared with other practices managed by the same provider. For example, we saw a record of an occasion when a patient had become aggressive towards a receptionist and had threatened to use violence. Although staff had remained calm and helped to diffuse the situation, the practice had reviewed a number of policies following the incident to mitigate the risks of staff coming to physical harm. This included a review of the practice's lone working policy to ensure that no member of staff was ever alone in the waiting area when the practice was open to the public. The practice had also arranged training in conflict resolution for all members of staff.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. 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. From the sample of three documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level 3. The healthcare assistant was also trained to level 3, all other staff were trained to child safeguarding level 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. 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.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The Director of Operations was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For instance, as a result of the most recent audit, infection prevention and control had been added as a standing item to practice meeting agendas.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

Are services safe?

- There were processes for handling repeat prescriptions which included the review of high risk medicines. The practice's patient record management system included a facility to audit the records of all patients prescribed with high risk medicines. For instance, this audit identified and reported the date of a patient's most recent pathology results, GP appointment and medicine review. We saw evidence that this audit was carried out monthly and there was an identified process to follow up where concerns were noted.
- Repeat prescriptions were signed before being issued to patients and there was a reliable process to ensure this occurred. The practice had additional processes in place to ensure that prescriptions for high risk medicines were managed safely. Although most repeat prescriptions for these medicines were sent electronically to patient's chosen pharmacists, those being due to be collected in person were stored separately from other prescriptions.
- The practice had a system in place to monitor prescriptions that had not been collected. Staff told us they checked these prescriptions weekly and would inform the GP if a prescription had not been collected within one week of the date of issue. The practice had carried out an audit of this process in November 2016 and as a result of this audit, had added an additional step to the procedure so that patient records were updated with more detailed information when a prescription was not collected. For instance, if a patient had not collected a prescription because they had also been prescribed the same medicine by a different care provider, a note would be added to the patient's record to make this clear.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Prescription pads were securely stored and there was a system to ensure these were recorded when issued or replenished back into stock. This system enabled all prescriptions to be safely tracked.

Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- Electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The provider also managed a neighbouring GP surgery and had put arrangements in place to move staff between the two practices when this was helpful. All staff normally employed in the other practice spent time shadowing experienced members of staff first to ensure they were familiar with some of the unique characteristics and challenges associated with a specialist homeless practice. The practice used a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

Outstanding ☆

Are services safe?

The practice had adequate arrangements to respond to 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.
- 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 and children's masks. A first aid kit and accident book were 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 stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The business continuity plan had recently been stress tested locally and at provider corporate level following a major cyber-related incident which had affected NHS services nationwide. The plan had been found to be effective for ensuring continuity of services.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. We saw examples of audits that had been undertaken following medical device alerts and medicine updates. The practice told us that audit parameters were saved on the computer system and run at regular intervals so the practice could identify if newly registering patients were affected by existing alerts or updates. For example, we saw one audit which had been undertaken following an alert from the Medicines and Healthcare products Regulatory Agency (MHRA). This alert had involved a contraceptive medicine and the practice had undertaken a monthly audit and had identified a patient affected by the alert in the most recent search. The practice had taken actions to contact the patient.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 84% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance around control of blood sugar was lower than local and national average, as only 55% of patients had well controlled blood sugar levels (CCG average of 78%, national average 78%). However, we saw unvalidated data for 2016/2017 which showed this had risen to 71%. The exception reporting rate for this indicator was 14% (CCG average 11%, national average 13%). Performance for other diabetes related indicators was comparable to CCG and national averages. For instance, the percentage of patients on the diabetes register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 80% (CCG average 85%, national average 80%) whilst 95% had a record of a foot examination and risk classification (CCG average 92%, national average 88%).
- Performance for some mental health related indicators was lower than CCG and national averages although unvalidated data for 2016/2017 showed that outcomes had improved for these indicators. For example, 70% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses (54 patients) had a comprehensive, agreed care plan documented in the record compared to the CCG average of 95% and national average of 89%. Unvalidated data for 2016/2017 indicated this had increased to 89% of patients (64 patients). The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 94% compared to the CCG average of 91% and national average of 89%. The percentage of eligible women with schizophrenia, bipolar affective disorder and other psychoses who had had a cervical screening test in the preceding 5 years was 94% (17 of 18 patients). The exception reporting rates for all mental health indicators were lower CCG and national averages.
- 72% of patients with hypertension (76 patients) had well controlled blood pressure compared to the CCG average of 90% and the national average of 83%. Unvalidated data for 2016/2017 indicated this had increased to 88%. The exception reporting rate for this indicator in 2015/2016 was 11% (CCG average 4%, national average 4%).
- Outcomes for patients with asthma (69 patients) were higher than national averages but lower than CCG averages. For instance, 84% had had an asthma review in the preceding 12 months using a nationally recognised assessment tool compared to the CCG average of 95% and the national average of 76%. The exception reporting rate for this indicator was 3% (CCG average 2%, national average 8%).

Good

Are services effective?

(for example, treatment is effective)

We asked the practice about the management of blood sugar levels for patients with diabetes. The practice told us that as a specialist homeless practice, a significant number of patients on the register experienced unique challenges managing blood sugar levels. For instance, we were told that patients without accommodation or whose accommodation arrangements were temporary or unstable, often found it very difficult to exercise meaningful choices around dietary management, including maintaining regular meal times and balanced diets. We were also told that a significant number of the practice population had more complex health and social problems, including multiple long term conditions, poor mental health and alcohol or substance misuse issues. The practice worked closely with local authority housing officers and a charity which helped homeless people, to support patients with their accommodation needs. The practice had also adopted a flexible appointment system so that patients with diabetes could access support in a way that better reflected their individual circumstances. For instance, there were no limits placed on the number of walk-in appointments available in a day and consultations were often up to an hour in length. This meant that GPs had more time to talk to a patient about their condition and provide advice and encouragement around the management of the condition. We saw unvalidated data for 2016/2017 which showed that 71% of patient with diabetes now had well controlled blood sugar levels which was an increase of 16% from 2015/2016.

There was evidence of quality improvement including clinical audit:

- There had been 11 clinical audits commenced in the last two years, four of these were completed audits where the improvements made were implemented and monitored. Audit topics were discussed and chosen at clinical meetings and were related to the needs of the practice population. For instance, most of the practice's patients had unstable accommodation arrangements which meant there was a risk that patients would not be able to engage with health screening programmes. We saw that an audit had been undertaken to check whether eligible patients were consistently being offered an invitation for bowel cancer screening. This audit had found that advanced search tools in the it's patient record system were not being used to full capacity which meant that some opportunities to identify eligible patients had been missed. The practice had developed a learning plan for staff and were implementing new processes to improve screening uptake rates at the time of this inspection. As part of the audit, the practice had also reviewed how patients were informed about test results and this had informed the protocol used by staff to ensure that contact numbers for patients were checked at every point of contact.

Findings were used by the practice to improve services. For example, the practice had carried out a three cycle audit to monitor the prescribing of oral anticoagulation treatment and to ensure that this treatment was being delivered safely. The audit had measured performance against three specific criteria; whether patients receiving anticoagulation treatment within the previous four months had an alert on the record, had relevant blood tests recorded within the previous three months and had not been issued with a prescription for anticoagulation treatment if blood tests had not been recorded within the previous three months. The first cycle had been undertaken in June 2016 and findings indicated that none of the patients receiving the treatment had an alert on the record although there was full compliance for the other criteria. As a result of this audit, the practice had immediately added an alert to relevant patient records so that prescribers would be reminded to check for documented blood test results in the medical record whenever they saw the patient. The practice had also reviewed procedures followed by reception staff when patients requested repeat prescriptions for anticoagulation treatment to ensure that patient records were always up to date and to prompt patients to have blood tests when these were overdue. A second cycle was carried out in October 2016 and this found full compliance with all criteria. When the practice carried out a third cycle in June 2017, there was full compliance with the requirement to have an alert on the record and recording of blood tests within the previous three months, however there was a single instance where the interval between a patients tests had been greater than three months but had a prescription issued. As a result of this, the practice had put steps in place to carry out a monthly search of all patients receiving anticoagulation treatment to ensure full compliance.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- 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. The provider also managed a neighbouring GP practice and had arrangements in place to allow staff to work in either practice in order to provide cover for annual leave or other absences. Staff from the second practice had been able to spend time shadowing practice staff and were familiar with the nature of the practice. This meant that patients visiting the practice were able to receive a consistent level of service when speaking with staff who were not normally based at the surgery.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff including those reviewing patients with long-term conditions. We also saw that the lead GP at the practice had undertaken specialised training around the care of patients who were homeless, had attended relevant conferences and learning opportunities and had contributed to learning in this field. For instance, they had recently been involved in a significant study around the causes of death in patients who were homeless and had co-authored a paper which outlined the findings of this study although this had not yet been published.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- 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 their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. All staff had also received training in conflict resolution and had access to and made use of e-learning training modules and in-house training.

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. The systems to manage and share the information that was needed to deliver effective care were coordinated across services and supported integrated care for people who used services.

Meetings took place with other health care professionals on a monthly basis when care plans were reviewed and updated for patients with complex needs. We saw minutes of multidisciplinary team meetings which showed how different agencies were working collaboratively to support individual patients. These meetings were attended by GPs, practice nurses, palliative care specialists and substance misuse clinicians as well as representatives from the co-located homelessness charity.

The practice was connected to a co-located hostel by an internal corridor and staff from the hostel told us that they would have daily conversations with clinicans and other staff around the care of their residents. We were told that the lead GP would often visit their office just to check whether any patients or hostel staff needed any support.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record..

The practice was aware of a risk that end of life care for patients who were homeless could be uncoordinated and often failed to take into account the needs of patients who were vulnerable because of their circumstances. We were told that many patients did not have access to family or friend support networks during serious illnesses. The practice had worked closely with the local palliative care team as well as local hospices to develop a strategy to support patients who were approaching the end of their lives. This support included helping patients to consider where they might prefer to die and whether they would like assistance with tracing or contacting family members. The practice could refer patients to a specialist bereavement counselling service when this was helpful. The lead GP at

Good

Are services effective?

(for example, treatment is effective)

the practice was involved in a study around the causes of death amongst people who were homeless and told us this would be used to further develop a compassionate approach to end of life care at the practice.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance and we saw evidence that staff had received training in this area, including the Mental Capacity Act 2005 and all doctors had undertaken Deprivation of Liberty Safeguards (DoLS) training.
- Although the practice did not have any children on the patient register, staff were aware that some patients had children who did not live with them but for whom they still had varying levels of caring responsibility. Staff were able to demonstrate an understanding of capacity to consent in line with relevant guidance and used this understanding when required.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits. Practice managers told us that consent practices were reviewed regularly to improve how people were involved in making decisions about their care and treatment. For instance, we were told that because patients were often uncomfortable signing consent forms, clinicians would take extra time to discuss the risks and benefits of any tests or procedures and would check the patient's understanding by asking the patient to explain what they had understood. These conversations were entered on the patient's record.

Supporting patients to live healthier lives

All patients registered at the practice were homeless and many were in need of additional support. Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people was used to do so.

For example:

- Smoking cessation advice was given by trained counsellors in the practice team. Due to the constant turnover of patients it was difficult to audit success rates of this intervention.
- The practice told us they sought to support patients to have positive and safe relationships. Advice was offered on pregnancy avoidance and safe sex. Free condoms were available from the clinical staff.
-
- Most of the practice population were in defined influenza clinical risk groups and were offered seasonal influenza vaccinations. The practice used text messages to advertise this service to patients and offered vaccinations opportunistically to patients who visited the practice. The practice uptake rate for this service was 90%.

The practice's uptake for the cervical screening programme was 77%, which was comparable with the CCG average of 79% and the national average of 81% although the exception reporting rate for cervical screening was 21% which was higher than the national average of 7%. The practice told us they were aware of the higher than average exeption rate and explained that some patients were resistant to being screened due to misconceptions about what was involved in the test. We were also told that many patients had limited engagement with health services over many years and were unaware of the existence or purpose of health screening programmes. We asked the practice how they encouraged eligible women to engage with the cervical screening programme and were told that staff took extra time to explain the benefits of cervical screening and had provided information about the screening programme during an open day at the practice. We were also told that when the practice nurse was seeing an eligible patient, they would always check the patients' record to see if a test was overdue or would fall due in the near future and would offer the patient an opportunity to have a sample taken opportunistically when this was the case. The practice told us they regularly audited patient records to identify patients who would benefit from advice around cervical screening and would invite these patients to make an appointment to discuss this and other screening programmes. The practice also demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker

Good

Are services effective?

(for example, treatment is effective)

was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice did not register patients under the age of 18 and did not offer childhood immunisations. Patients of the register who were parents or carers of children and younger people were supported to register at other GP practices where childhood immunisations were available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. Uptake rates for these programmes were lower than local and national averages, the practice uptake rate for bowel cancer screening was 43%, compared to the national average of 58%, whilst the uptake rate for breast cancer was 60% compared to the national average of 73%. The practice had carried out an audit to identify eligible patients whose accommodation arrangement meant they had not received an invitation to these screening programmes. We were told that results from this audit were being reviewed to identify where improvements could be made.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect. During our inspection, we noted that staff recognised and greeted every patient who visited the practice by name.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- We observed staff display patience and compassion when speaking with patients who were distressed. Reception staff knew that if patients wanted to discuss sensitive issues they could offer them a private room to discuss their needs. The practice had assessed this to mitigate any risks involved. For instance, all rooms had emergency call buttons.
- We observed that when some patients started to discuss their private medical issues with reception staff, those staff gently reminded them that these matters were confidential and encouraged the patient to speak more discretely. Staff were also careful not to say anything during these conversations which might breach the patient's right to privacy.
- The practice told us that many patients had pet dogs and these were allowed in the practice waiting area although not in clinical areas. The practice had arrangements in place with a national dog welfare charity to provide important support, free of charge, to dog owners. For instance, patients could have their pets microchipped or receive essential equipment including collars, leads, winter coats, grooming products and feeding bowls.
- The practice allowed patients to stay and socialise in the waiting area before and after appointments. The practice told us this meant that some patients who had experienced social isolation had begun to develop a sense of community and had formed friendships with other patients.

All of the 13 patient Care Quality Commission 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, patient and treated them with dignity and respect.

We spoke with five patients. They told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. We were told that the reception team were always pleasant and generous with their time. More than one patient told us there had been occasions when the conversations they had with reception staff were the only conversations they might have in an entire day and this level of respectful contact was very important to them.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was rated above others for its satisfaction scores on consultations with GPs and nurses. For example:

- 83% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 87%. Unvalidated data from the 2017 National GP Survey showed that 95% of patients now said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 91% of patients said the GP gave them enough time (CCG average of 86% national average 87%). Unvalidated data from the 2017 survey showed this had risen to 95%.
- 98% of patients said they had confidence and trust in the last GP they saw (CCG average of 91%, national average of 92%). Unvalidated data from the 2017 survey showed this had risen to 100%.
- 64% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 83%, national average 85%). The practice had undertaken an internal survey to find why patients satisfaction was lower for this question and had identified that patients felt they received more personal treatment when they saw the same doctor regularly. As a result, GPs had agreed to fix their individual sessions on set days and had let patients know when their

preferred doctors would be available. Unvalidated data from the 2017 National GP Survey showed that 100% of patients now said the last GP they spoke to was good at treating them with care and concern (CCG average 84%, national average 86%).

- 94% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 91%.
- 96% of patients said the nurse gave them enough time (CCG average 89%, national average 92%).
- 100% of patients said they had confidence and trust in the last nurse they saw (CCG average 96% national average 97%).
- 80% of patients said the last nurse they spoke to was good at treating them with care and concern (CCG average 86%, national average 91%). Unvalidated data from the 2017 survey showed this had risen to 97%.
- 94% of patients said they found the receptionists at the practice helpful (CCG average 86%, national average 87%).

The views of external stakeholders were positive and in line with our findings. For example, we spoke with a local authority housing officer who worked at the practice three days per week and they told us that they found staff at the practice to be diligent, energetic and compassionate in their support of patients. They told us that practice staff encouraged and helped patients to engage with housing agencies and other support services and that the tenacity and dedication shown by practice staff was a significant contributory factor in resolving the accommodation needs of many patients. We also spoke with a case worker from a homelessness charity who had worked closely with the practice for a number of years. This charity managed a 65 bed hostel in a building adjacent to the practice and the majority of residents were or had been patients at the practice. We were told that the practice provided care to patients in a way that was respectful and dignified. We were also told that GPs and other clinical staff were always willing to provide advice to staff around helping residents safely assume greater responsibility for their own care.

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. We also saw that care plans were personalised.

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

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 86%. Unvalidated data from the 2017 survey showed this had risen to 100%.
- 72% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 80%, national average 82%). Unvalidated data from the 2017 survey showed this had risen to 96%.
- 94% of patients said the last nurse they saw was good at explaining tests and treatments (CCG average 85%, national average 87%). Unvalidated data from the 2017 survey showed this had risen to 97%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG average 81%, national average 85%). Unvalidated data from the 2017 survey showed this had risen to 100%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- The practice had reviewed the patient list and had identified that significant numbers of patients spoke Polish and Vietnamese. The practice had been able to arrange for a Vietnamese speaking interpreter from a local hospital to visit the surgery weekly and this person helped vulnerable Vietnamese speaking patients to understand and navigate care pathways. The practice directly employed a Polish speaking interpreter who

could assist with translation during consultations and help Polish speaking patients understand and access other health providers. Both interpreters had received DBS checks.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).
- A significant number of patients did not have permanent accommodation and had experienced difficulties receiving postal services. This included important letters concerning referrals and other health related matters. The practice encouraged patients to register using the practice address and would hold mail on patient's behalf until they were able to collect it in person. The practice told us that in addition to providing an important service for patients, this was a key part of the strategy to facilitate patient's engagement with other health providers and to improve participation in screening programmes.
- Reception staff had noted that practice patients frequently changed telephone numbers and that telephone numbers were sometimes shared by more than one patient. A protocol had been put in place through which reception staff would check latest contact details with patients at every point of contact. This included asking if a number was shared with any other patient so that arrangements to ensure confidentiality could be reviewed. Staff told us this had improved their capacity to contact patients, for instance those who did not attend appointments or who had pathology results outstanding.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified seven patients as carers (less than 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

The practice told us that the nature of their population group meant that patients often had complex family backgrounds which could add to the distress experienced during times of bereavement.

Staff told us that they were sensitive to this and would consider how to react to each bereavement on an individual basis. We were told that bereaved patients were usually offered a GP appointment and bereavement counselling as a minimum. Staff also told us that they would refer or signpost patients towards additional support where this was helpful. For instance, the practice told us they would try to find specialist support for patients who were estranged from their families or who needed emergency funding to attend a funeral.

The practice also explained that a significant number of patients had become homeless following a family bereavement and that they would support patients to access bereavement counselling years after a loss.

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 particular characteristics of their patient population which were people who were homeless or living in precarious accommodation. People's individual needs and preferences were central to the planning and delivery of tailored services. The practice structured services to be flexible, to provide choice and to ensure continuity of care. Practice managers told us that over the years the patient-profile had changed frequently and the practice had sought to ensure that the services provided reflected these changes.

- A significant number of patients at the practice had multiple conditions or complex care needs and the practice had adopted a flexible approach to the length of appointments so that patients could usually discuss several issues during the same appointment.
- The practice did not place a limit on the number of walk-in appointments available on any day so that patients who found it difficult to book appointments in advance or who struggled to adhere to scheduled appointments, could access GP services in a way that suited them
- The practice' computer system would alert staff to all of the outstanding care needs of patients who visiting the practice. This helped clinicians provide more effective care for patients who preferred to attend the practice infrequently.
- The practice sent text messages to patients to remind them to attend appointments or to alert them when they were due to have a health or medicine review. The practice had a protocol in place to review patient's contact details during every point of contact to maximise the effectiveness of the text message reminder system.
- A specialist substance and alcohol misuse clinician at the practice offered and delivered alcohol and substance reduction programmes. Patients who were experiencing difficulties engaging with reduction programmes were referred to a local service where more intensive support was available. The substance misuse clinician and the lead GP had a meeting before every clinical session and would discuss the care plan for each patient with an appointment. Patients attending this clinic who had not recently seen a GP were encouraged to see the doctor and would be accommodated on the same day where possible. This meant that GPs were able to undertake opportunistic health and medicine reviews. The substance misuse clinician was part of team of clinicians employed by a specialist organisation and could call on the support of other team members when this was helpful.
- The substance misuse clinician provided two clinical sessions per week. Appointments at this clinic were available for practice patients whose substance or alcohol misuse was stable or those who were reducing or had stopped using substances or alcohol entirely. The substance misuse clinician met with GPs before and after every session and supported patients with a range of tools including counselling and cognitive behaviour therapy. This clinician also collaborated with the housing team based at the practice to provide specialist support for patients moving into new accommodation. Patients whose misuse was more chaotic were referred to a local facility which was able to provide more intensive support.
- The practice was aware that patients were not always able to exercise choice around location when they were residing in hostels or other temporary accommodation and approximately 30% of the practice population lived outside the CCG area at any one time. The practice encouraged these patients to remain on the practice list until their accommodation arrangements became more stable and this meant that patients could have continuity of care by the same GPs.
- Patients could have their post sent to the practice if they needed an address. In addition to the inherent practical benefits to patients, this also provided an incentive to attend the practice more often. Practice staff told us that whenever patients visited to collect their post, they would check their records and if they had any outstanding care needs, would encourage them to see a clinician whilst they were in the building.
- The practice had made an arrangement with the operator of a chain of sandwich shops to provide a supply of healthy foods, including sandwiches and fruit, to the practice. This food was provided free of charge to patients. GPs told us that as well as providing patients

with a decent meal, this also improved attendance at appointments and health reviews and this had contributed to improved outcomes for patients with long term conditions.

- The practice provided shower facilities for patients and offered free shower consumables, including towels, to patients who needed them. We saw this service being accessed several times during the inspection. Patients who used this service told us this was very important to them.
- The practice provided rooms for use by a number of other organisations for the benefit of its patients. For example a social justice charity, ran weekly clinics to help patients with accessing education, benefits, debt counselling and legal advice.
- The practice was co-located with local authority housing officers and a charity that helped homeless and vulnerable people to find their own homes. The practice worked collaboratively with these by referring patients who wished to transition from being homeless to having settled accommodation. This meant that patients could receive health care and housing support in one place. One housing officer we spoke with told us it was frequently the case that making initial contact with homeless patients was particularly difficult and the practice helped to overcome this by referring patients directly to housing officers in the same building and by providing valuable supporting information which helped them to find accommodation which was suitable for patient's needs. We were told that housing officers provided support to an average of 60 of the practice's patients every week. This joined-up approach had recently been recognised by the local authority when the practice, the charity and the housing team had jointly received the 'Hackney Project of the Year' in recognition of their contribution to tackling both the health and housing needs of homeless people.
- The practice premises adjoined a 68 bed hostel which provided temporary accommodation for homeless people. The practice provided GP services to residents at this hostel as well as providing advice and support to staff who worked there. We spoke with staff from the charity who managed the hostel and they told us the GPs would carry out home visits for patients who were unable to attend the surgery and would assist ambulance crews called to the hostel. We were told that staff at the hostel spoke with GPs on a daily basis when they could discuss patients who required additional support, for instance around management of long term conditions, treatment for substance or alcohol misuse or advice around managing symptoms experienced by some patients during detoxification. We were also told that GPs would accompany hostel staff visiting residents who did not recognise or were not prioritising, their own health care needs and would encourage them to engage with the practice.
- The practice told us they had reviewed the practice list within the previous year and had identified an increasing number of Polish and Vietnamese speaking patients registering. The practice had arranged for a Vietnamese speaking interpreter from a local hospital to attend the practice weekly and had employed its own Polish speaking translator who also attended the practice one day per week. Patients we spoke with told us this was a valuable service which had been instrumental in helping them to engage with their own health or receive treatment. The practice website allowed a user to have the website translated into any of 100 different languages.
- The practice hosted additional services to help patients access specialised care locally. For instance, the practice hosted weekly sessions with a psychotherapist, diabetic nurse and a podiatrist. The practice also hosted a social prescriber who could signpost patients towards support organisations or recommend activities which could have a therapeutic effect.
- A significant number of practice patients could only access the practice website using mobile telephone and the practice website had been designed to work optimally with mobile devices. Patients could use the website to access a range of services, including booking appointments, requesting repeat prescriptions and find information about self-care of common conditions.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate. For instance, the practice would print maps and easy to read directions to help guide patients who needed to visit other care providers who were based in the community.

Access to the service

The practice was open between 8am and 6:30pm Monday to Friday. Appointments were from 8am to 6pm daily. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages.

- 96% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 76%.
- 95% of patients said they could get through easily to the practice by phone (CCG average 76%, national average 73%).
- 84% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment (CCG average 75%, national average 76%).
- 98% of patients said their last appointment was convenient (CCG average 91%, national average 92%).
- 98% of patients described their experience of making an appointment as good (CCG average 73%, national average 73%).
- 68% of patients said they don't normally have to wait too long to be seen (CCG average 54%, national average 58%).

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had found that patients were often reluctant to pursue complaints, particularly in writing. The practice recorded all complaints made verbally. Staff told us they encouraged patients to raise concerns when they had them and that they would explain to patients that complaints were an opportunity for the practice to learn.

- The practice 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 looked at four complaints received in the last 12 months, all of which had been received verbally, and found that these had been managed in line with practice policy. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, we saw a complaint from a patient who felt they could not always see the same clinician during appointments. We saw evidence that the practice had met with the patient and explained which days of the week each clinician worked. The practice had also shown the patient how to use the online booking system so they could arrange their appointments on a day when their preferred clinician was at the surgery.

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 leadership and culture of the practice was used to drive improvements and deliver high quality patient-centred care. The practice used innovative and proactive methods to improve patient outcomes, working with other organisations to deliver the best outcomes and deliver care to the practice population wherever possible. For instance, the practice sought to create arrangements with other care providers and support organisations to provide services from the practice's premises in order to improve access for patients who often experienced barriers to receiving care.

The practice shared with us a clear vision, mission and values which were to tackle health inequalities and improve access to the highest quality care for homeless people and to achieve this through teamwork, education, evidence-based medicine and research. Staff we spoke with on the day were engaged and fully aware of their responsibilities to fulfil the vision.

The practice had a comprehensive strategy and supporting practice development plan which was built around the unique nature of the practice, but which benefitted from the central resources provided by its parent organisation, including advanced IT support, HR management and research support. Practice managers and staff were encouraged to reflect on the vision and values of the practice when planning or implementing new services and the development plan was reviewed annually. The practice business plan had a number of actions based on improving the quality and effectiveness of the service. For example, reviewing how frequently consulting rooms were not in use and considering what extra services could be provided at the surgery during these times.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly. We saw that document control processes were in place to ensure that staff always had access to the latest version of every policy.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- There was clear evidence of quality improvement including clinical audit. We saw that the practice had put in place a comprehensive audit programme which was driven by the needs of the practice population in order to improve patient outcomes. This also ensured that audits were completed through to their second cycle in order to monitor the changes and any improvements made
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. We saw evidence that when reviewing risk, the practice routinely considered risks to patient's physical and mental well-being. For instance, when patients had requested that clothes hooks be placed in the shower room the practice had considered whether this might present an opportunity for self-harm. In order to mitigate this risk but still provide proper facilities, the practice had undertaken detailed research and had sourced a specialised collapsible clothes hanger which would detach from the wall if excess weight was applied.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.
- The practice utilised a social networking and social microblogging site to communicate with peers and used this to access support and advice when this was helpful, for instance around software issues or queries around vaccination programmes.

Leadership and culture

Leaders had an inspiring shared purpose and sought to encourage and motivate staff to succeed. On the day of inspection the management team demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised reducing inequality and promoting access to safe, high quality and compassionate care for homeless patients.

Are services well-led?

Outstanding ☆

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

Staff told us managers were approachable and always took the time to listen to all members of staff. Managers told us that staff were hard-working, professional and committed to the vision of the practice.

Throughout the inspection, we saw that staff consistently treated patients with compassion and respect and patients we spoke with told us this was normal at this practice. For instance, we saw one member of the reception team leave their desk to sit and talk with a patient who was distressed. We saw that patients were happy to engage in conversations with staff about their day to day lives and saw that in addition to being personable to patients, staff used these as opportunities to encourage patients to consider how talking with a social prescriber could lead to positive experiences.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The management team encouraged a culture of openness and honesty. From the sample of four documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with community nursing services, mental health clinicians, homelessness support workers and substance misuse clinicians to monitor vulnerable patients.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the managers in the practice. All staff were involved in discussions about how to run and develop the practice, and the management team encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work, spoke highly of the culture and told us they felt they had shared ownership of the values of the practice. There were consistently high levels of constructive staff engagement.
- We saw evidence the commitment of managers and staff to tacking inequality extended beyond the workplace. Several members of staff were involved in volunteer projects to support homeless people. For instance, the lead GP volunteered at a non-governmental organisation that sought to empower people whose circumstances made them vulnerable and at risk of being excluded from accessing healthcare. They were also a member of the Faculty of Homeless and Inclusion Health, and were involved in a project to develop a citywide registration template for homeless patients which could be used to improve data collection and information sharing across CCGs. Other members of staff volunteered at homeless shelters and befriending services for people who were homeless.

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

The practice encouraged rigorous and constructive challenge from people who used services and other stakeholders and regarded this as a vital way of raising standards and improving how services were delivered to patients.

- The practice held an open day in May 2016 and used this event to gather feedback whilst also promoting the range of services provided by the practice and other health care services available in the local community. For instance, the event had been used to ask patients which services they would benefit from being located at the practice. This event had been attended by Hackney Diabetes Centre who offered glucose testing and advice on the management of diabetes, whilst the Community Dental Service Team delivered free oral health screening and advice.
- The practice engaged with the NHS Friends and Family test and ensured that verbal complaints were recorded

Are services well-led?

Outstanding ☆

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

and reviewed by managers. The practice encouraged staff to speak openly at staff meetings and during appraisals.. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

- Staff at the co-located hostel and local authority housing officers who were based at the practice told us their contribution to reducing inequality was fully recognised by the practice and they were included in conversations about service delivery and that their views were considered carefully.

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 pilot schemes to improve outcomes for patients in the area.

For instance, the practice was working closely with a charity that provided drug and alcohol treatment and recovery services to improve access to specialist HIV clinicians at the surgery. Practice patients receiving treatment for HIV could attend appointments with HIV consultants who held joint clinics with GPs at the practice.

The practice had built strong working relationships with other stakeholders in the local health economy and had developed information sharing protocols to ensure that these relationships were sustainable and made an effective contribution to reducing inequality. This included arrangements to provide local authority housing officers with information in support of patient accommodation applications, and up to date care plans to community health providers.

GPs at the practice were involved in research to improve understanding of how homelessness affected people's health. One of the GPs had undertaken an advanced qualification in medical anthropology and had undertaken extensive ethnographic fieldwork to identify hidden barriers to health access within the homeless demographic. They were using this study to improve outcomes for patients at the practice. For instance, this field work had involved an in-depth review of the causes of death amongst homeless people and this research had influenced the practice's policy of offering an unlimited number of walk-in appointments so that patients could receive expert care when it was needed.