Great Chapel Street Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Great Chapel Street Medical Centre on 19 May 2015. Overall the GP practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients were able to access shower facilities and clean clothes on request at the practice.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw three areas of outstanding practice:

- The practice provided an outreach service out of hours in which the practice nurse and the Social Advocacy Worker would access homeless shelters and search for homeless people on the street to reach people with complex needs who may find it difficult to engage with health and social care providers.
- The practice employed a Social Advocacy Worker who was available five days per week to provide patients with housing, benefits and employment advice. The Social Advocacy Worker assisted patients with job applications, represented patients at court hearings in relation to benefits sanctions and liaised with re-housing services to access temporary or permanent accommodation for patients.
- Practice staff provided training for staff working in other organisations for the homeless such as hostels in relation to monitoring of medicines and management of aggression.

However there were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure all non-clinical staff are have access to formal essential training such as safeguarding and basic life support.

Importantly the provider should:

- Ensure there is an audit trail for information received at the practice from hospital outpatient departments.
- Advertise the chaperone service to inform patients this service is available within the practice.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, not all of the non-clinical staff had received formal safeguarding training. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed however, not all non-clinical staff had received basic life support training.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Clinical staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

There was a proactive approach to understanding the needs of the practice population and to deliver care in a way that meets these needs and promotes equality. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers. The practice offered services which were flexible, provided choice and were accessible. People could access appointments and services in a way and at a time that suited them.

The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG).

Fifty-eight of 72 patients surveyed as part of the practice patient survey described their experience of making an appointment as good. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people
Not rated.

People with long term conditions
Not rated.

Families, children and young people
Not rated.

Working age people (including those recently retired and students)
Not rated.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

The practice provided an outreach service out of hours in which the practice nurse and the Social Advocacy Worker would access homeless shelters and search for homeless people on the street to reach people with complex needs who may be difficult to engage with health and social care providers.

The Social Advocacy Worker was available five days per week to provide patients with housing, benefits and employment advice. The Social Advocacy Worker assisted patients with job applications, represented patients at court hearings in relation to benefits sanctions and liaised with re-housing services to access temporary or permanent accommodation for patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia)

The practice had a high prevalence of patients with severe mental illness and personality disorder.The practice supported and contributed to the Personality Disorder Network in Westminster in which professionals are able to discuss and receive advice with complex patient cases.

Summary of findings

The practice had developed an integrated mental health team that worked with the practice including a psychiatrist, mental health nurse and counsellor.

The psychiatrist was based at the practice one day per week. The counsellor worked at the practice three days of the week and provided general counselling for patients including bereavement counselling. GPs would refer patients to the psychiatrist, in-house counsellor or refer them to Improving to Access Psychological Therapy (IAPT).

The practice had recognised that drug and alcohol abuse was prevalent amongst the homeless population and drugs and alcohol advice with a Mental Health nurse was provided for patients five days per week.

Summary of findings

What people who use the service say

There was no data available for the national GP Survey as a result of the population served by the practice having no fixed abode. The practice had carried out its own patient survey which found:

- 65 of 69 patients surveyed were satisfied with the practice's opening hours.
- 58 of 72 patients surveyed described their experience of making an appointment as good.
- 63 of 71 patients were satisfied with the waiting time for their appointment.
- 55 of 63 patients surveyed found the service easy to access.
- 69 of 74 patients surveyed found the staff to be friendly and helpful.
- 65 of 73 patients surveyed said staff were good at explaining what they needed to know.
- 65 of 76 patients surveyed said staff were good at answering all their questions.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 28 comment cards and the vast majority were all positive about the standard of care received. Patients stated staff were friendly, helpful and sensitive to their needs.

Areas for improvement

Action the service MUST take to improve

- Ensure all non-clinical staff are have access to formal essential training such as safeguarding and basic life support.

Action the service SHOULD take to improve

- Ensure there is an audit trail for information received at the practice from hospital outpatient departments.
- Advertise the chaperone service to inform patients this service is available within the practice.

Outstanding practice

- The practice provided an outreach service out of hours in which the practice nurse and the Social Advocacy Worker would access homeless shelters and search for homeless people on the street to reach people with complex needs who may find it difficult to engage with health and social care providers.
- The practice employed a Social Advocacy Worker who was available five days per week to provide patients with housing, benefits and employment advice. The Social Advocacy Worker assisted patients with job applications, represented patients at court hearings in relation to benefits sanctions and liaised with re-housing services to access temporary or permanent accommodation for patients.
- Practice staff provided training for staff working in other organisations for the homeless such as hostels in relation to monitoring of medicines and management of aggression.

Great Chapel Street Medical Centre

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 CQC Inspection Manager, a GP Specialist Adviser and an Expert by Experience. Experts by Experience are people who have direct experience of using health and social care services.

Background to Great Chapel Street Medical Centre

Great Chapel Street Medical Centre is a walk-in one stop shop for the homeless adult population in Westminster. This includes those who are rough-sleeping; are at risk of or have significant history of rough sleeping; or are resident in a hostel in Westminster or an adjacent area. The practice provides GP primary medical services, psychiatry, dentistry and podiatry services and social advocacy /housing and counselling to homeless people in the London Borough of Westminster.

The practice team are made up of four GPs, two nurses, a general manager, a Social Advocacy Worker, a receptionist, two mental health specialists, a dentist and dental nurse, a counsellor and podiatrist.

The practice opening hours are between 10:00am-5:00pm, Monday to Friday. Telephone access is available during core hours. The practice has an Alternative Providers of Medical Services (APMS) contract (APMS is one of the three contracting routes that have been available to enable the commissioning of primary medical services). The practice refers patients to the NHS '111' service for healthcare advice during out of hours.

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

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

We also looked at how well services are provided for:

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 May 2015. During our visit we spoke with a range of staff including GPs, nurses, the practice manager, the social advocacy/housing lead and administrative staff and spoke with patients who used the service. We observed how people were being cared for, talked with patients and reviewed personal care or treatment records. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety, for example significant events, incident reports, complaints and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Staff told us they would inform the practice manager of any incidents and there was also a significant event recording form available on the practice's shared drive.

We reviewed minutes of practice meetings where incidents and complaints were discussed during the last 12 months and we also reviewed incident reports which had been collated for two years. Lessons were shared to make sure action was taken to improve safety in the practice. For example, as a result of an aggressive incident involving an intoxicated patient, staff were reminded of the practice's strict rules on alcohol consumption in the clinic and refusal to see anyone who was intoxicated.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Patients we spoke with during the inspection told us they felt their care and treatment at the practice was safe.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the practice nurses was the nominated lead for safeguarding. The nurse attended safeguarding case conferences when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities however, we found not all of the non-clinical staff had received formal safeguarding training.
- The practice had a chaperone policy but there was no notice displayed in the waiting room, advising patients this service was available. All staff who acted as chaperones were trained for the role and had received a disclosure and barring service check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice, kept patients safe (including obtaining, prescribing, recording, handling, storing and security). There was a medicines management policy in place and a cold chain procedure was kept on a clipboard in the treatment room for quick access for staff. Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out in line with the practice's recruitment policy and the four files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For

example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All clinical staff had received annual basic life support training however this had not been provided for all non-clinical staff. Emergency medicines were available in the treatment room. The practice had a defibrillator available on the premises, oxygen with adult and children's masks and a pulse oximeter (used to check the level of oxygen in a patient's bloodstream). Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. Staff used the NICE Clinical Knowledge Service which provides primary care practitioners with summaries of the current evidence base and practical guidance on best practice.

GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. Clinical guidelines were also discussed with the local CCG meetings which staff attended. We saw evidence of NICE guidance relating to the referral of patients using a suspected cancer pathway referral for an appointment within two weeks, on the shared drive for clinical staff to access. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

Management, monitoring and improving outcomes for people

The practice did not participate in the Quality and Outcomes Framework (QOF) but staff told us they had future plans to engage with this programme. (This is a system intended to improve the quality of general practice and reward good practice). Staff explained it was difficult to monitor patient outcomes as they recognised it was hard to engage the practice population to attend for formal follow-ups and routine blood tests. In response to this issue staff told us they did as much as they could for the patient in one visit. Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients' outcomes. We saw evidence of two clinical audits completed in the last two years. These were completed audits where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example, as a result of one audit the practice had managed to reduce urology referrals from 111 to 93 during a three month period.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: fire procedures and information governance awareness. However, we found not all non-clinical staff had received essential training such as safeguarding and basic life support. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

Staff told us part of the success of the service they provided for patients was as a result of the support and collaboration with various external organisations such as the Central & North West London Mental Health Trust, Central London Community Healthcare, Community Mental Health Teams, Drug Dependency Units, Social Services, housing providers and rehabilitation centres.

The practice supported and contributed to the Personality Disorder Network for Westminster in which professionals are able to discuss and receive advice with complex patient cases. The practice also engaged in discussion forums and multi-agency strategic consultation meetings to discuss policies affecting homelessness.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. Staff providing the outreach service also worked closely with A&E departments and

Good

Are services effective?

(for example, treatment is effective)

provided training for staff working in other organisations for the homeless. For example, staff told us they provided training for hostel staff relating to monitoring of medicines and management of aggression.

We saw evidence that multi-disciplinary team meetings took place on a weekly basis and complex cases were discussed and care plans were routinely reviewed and updated.

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. This included care and risk assessments, care plans, medical records and test results. However, we found there was no audit trail for information received from hospital outpatients and therefore there was a potential risk of information being missed and not processed.

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

Consent to care and treatment

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

Health promotion and prevention

It was practice policy to offer an extended new patient health check to all new patients who attended the practice and we saw evidence to confirm this. Appropriate follow-ups on the outcomes of health assessments and checks were offered to patients, where abnormalities or risk factors were identified.

Staff explained flu vaccinations were offered to all patients as the practice recognised that their patient population were all at risk. Pabrinex (a course of up to 3 vitamin injections for heavy alcoholics who appear at risk of brain injury as a result of their alcohol use) were provided opportunistically for patients. D-dimer tests (used to identify the presence of an inappropriate blood clot) were also provided for patients where necessary. A smoking cessation clinic was held each week for patients requiring advice and support to quit smoking.

Patients who may be in need of extra support were also identified by the practice. These included those at risk of developing a long-term condition and those requiring support in other areas such as benefits, employment and housing. Patients were then signposted to the relevant service.

Clinical staff told us they used 'Patient UK' which is an online resource providing information on health, lifestyle, disease and other medical related topics. The website provides information on health related topics in the form of comprehensive leaflets (which can be read online or printed), blogs, wellbeing advice and videos. Staff working in the outreach service provided information leaflets and health promotion advice for people they met during these sessions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

The vast majority of the 28 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the practice patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. For example:

- 66 of 73 patients surveyed said the staff were good at listening to them.
- 65 of 68 patients surveyed said staff gave them enough time.

Care planning and involvement in decisions about care and treatment

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

Results from the practice patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 65 of 73 patients surveyed said staff were good at explaining what they needed to know.
- 65 of 76 patients surveyed said staff were good at answering all their questions.

Patient and carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this feedback. For example, patients described how staff responded sensitively to their needs and were supportive. The practice survey showed 69 of 74 patients surveyed found the staff to be friendly and helpful.

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found people's individual needs and preferences were central to the planning and delivery of tailored services. There was a proactive approach to understanding the needs of the practice population and to deliver care in a way that meets these needs and promotes equality.

The practice provided a 'one-stop' service where patients could receive all areas of healthcare and social needs in one place. The practice worked as a cohesive team and practice staff were able to inter-refer patients to other members of staff working in the centre. For example, patients receiving treatment from GPs or practice nurses could be referred for dental, psychiatric, podiatry and alcohol, drugs and mental health services within the practice. Patients seeking housing, benefits and employment advice could be referred to the Social Advocacy Worker. The Social Advocacy Worker gave us examples of help offered to patients which included assistance with job applications, representation for court hearings in relation to benefits sanctions and liaison with re-housing services. In this way, patients multiple needs were addressed through opportunist engagement.

The practice offered a patient centred and flexible service which went beyond essential medical care interventions. For example, staff were able to accompany patients to receive specialist interventions from hospital services and other service providers and patients were able to access shower facilities and clean clothes on request at the practice.

We found there were innovative approaches to providing integrated person-centred pathways of care that involved other service providers. Staff told us that research indicated that 50% of all rough sleepers in London were in Westminster and that rough sleepers had a life expectancy up to 40 years less than the national average. In response to this data, the practice also provided an outreach service out of hours in which the practice nurse and the Social Advocacy Worker would access homeless shelters and search for homeless people on the street to reach people with complex needs who may find it difficult to engage with health and social care providers. The practice nurse gave us an example of patient centred care and the flexible service provided which related to a homeless person they met during an outreach session outside a local church. The practice nurse explained whilst mainstream GP services were able to provide home visits for patients who are too ill to visit the practice; she had repeatedly visited the homeless person stationed outside the church in order to provide him with care and treatment for his leg as part of the outreach service.

The practice was registered with Westminster Foodbank as a distributor of Foodbank vouchers for people identified in a crisis. On presenting their voucher at the Foodbank centre, people can receive a hot drink and a food bag and are also signposted to other services where appropriate.

Access to the service

The practice offered services which were flexible, provided choice and were accessible. People could access appointments and services in a way and at a time that suited them. The walk-in service did not require any pre-booked appointments however, staff told us pre-booked appointments were offered for patients who wanted or needed longer consultations. The medical centre was open between 10:00am and 5:00pm Monday to Friday.

GP appointments were available from 11:00am-12:30pm on Monday, Tuesday and Thursdays and 2:00pm-4:30pm daily. Nursing appointments were available from 10:00am-12:30pm and 2:00pm-4:30pm daily.

Patients could access housing, benefits and employment advice and support daily via the Social Advocacy Housing Advisor Worker.

The practice had recognised that drug and alcohol abuse was prevalent amongst the homeless population and drugs and alcohol advice with the Mental Health nurse was provided for patients from 10:00am-12:30pm and 2:00pm-4:30pm daily.

Dental treatment was available by appointment from the in-house dentist on Tuesday's and Thursday's however staff told us that emergency appointments were accommodated as required.

A drop-in podiatry service was provided for patients on Friday's between 9:00am-12:30pm.

Psychiatry appointments were available for patients by appointment on Tuesday's between 11:00am-1:00pm and

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

2:00pm-4:30pm. A counselling service was provided as a drop-in session on Mondays between 10:00am-12:00pm and 2:00pm-4:30pm on Thursdays and by appointment on Wednesdays 10:00am-4:30pm.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. There was a sign outside of the practice which informed patients of the opening hours and this was also advertised in the practice leaflet and the practice website. Patients were provided with information about the NHS 111 service in the practice leaflet and there was an answerphone message which directed patients to this service when the practice was closed.

Staff told us that the practice served a population of mixed ethnicities. Some staff members were able to speak additional languages including Spanish, French, Italian and Turkish. The practice could cater for other languages through the use of a telephone translation and interpreting service. The practice also had a hearing loop system available to assist patients with reduced ranges of hearing.

Results from the practice patient survey showed that patients were generally satisfied with how they could access care and people we spoke to on the day were able to get appointments when they needed them. For example:

- 65 of 69 patients surveyed were satisfied with the practice's opening hours.
- 58 of 72 patients surveyed described their experience of making an appointment as good.
- 63 of 71 patients were satisfied with the waiting time for their appointment.
- 55 of 63 patients surveyed found the service easy to access.

The premises were accessible to patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The GP partner, practice manager and Social Advocacy Worker were designated leads who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the practice leaflet, on the practice website and posters explaining the procedure were displayed in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. We saw that one complaint related to the practice not providing methadone. Staff had attempted to educate patients regarding the services provided at the practice which did not include the prescribing of barbiturates, benzodiazepines, tranquilisers, opiates or amphetamines by clearly advertising this in the waiting area, the practice leaflet and on the practice website.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to improve access for homeless people to health services, improve the health of the homeless population by recognising and addressing the multiple social and medical needs of this patient group and to provide continuity of care for patients. There was a clear objective to address social inequalities and ensure that a vulnerable group of men and women, often with high morbidity and mental health needs, received good access to primary health care and onward referral. We found details of the vision and practice values on the practice website and in the practice leaflet.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

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 in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

However, we found not all non-clinical staff had received essential training such as safeguarding and basic life support and therefore the governance arrangements for staff training needed to be improved.

Leadership, openness and transparency

The management team in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. One of the GP partners and the practice manager were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. One day of the week the GP partner spent undertaking managerial practice duties and also chaired the multi-disciplinary team meetings. The management team encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held each week and the meeting minutes were available to any staff members who were unable to attend. Staff told us they felt confident to raise issues at team meetings and felt supported if they did. Staff said they felt respected, valued and supported. 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.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG of approximately 10 members who met every quarter and had submitted proposals for improvements to the practice management team. For example, patients wanted a notice board stating which practice team members were available on a day to day basis. We observed this had been implemented with a white board in the reception area which listed names of staff on duty.

The practice strived to ensure the PPG was as inclusive as possible for patients and arranged for translators to be in attendance at meetings where necessary. Staff told us they had recognised that obtaining honest and objective feedback from their patients was particularly difficult. This was because homeless people had indicated they were accustomed to receiving poor services and were therefore biased in their opinions of the practice. We saw evidence in the PPG meeting minutes of staff encouraging patients to be open and honest about what was not working well in the practice.

As a result of comments and suggestions received from patients through a practice survey, plans were in place to improve the waiting area and staff told us they had received a grant to redecorate the practice.

Are services well-led?

Good

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

The practice had also gathered feedback from staff through staff meetings and appraisals. Staff told us the multidisciplinary team meetings were an open forum for feedback and they would not hesitate to discuss any concerns or issues with colleagues and management. For example, the practice manager had installed a person safety security system within the practice to improve the safety of staff and mitigate the risk of violent and aggressive incidents. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and encouraged staff to discover and propose new ideas to improve outcomes for patients. For example, the outreach programme was developed by one of the practice nurses and staff told us there was latitude to develop the nursing service provided at the practice.

Future plans for the practice included access to emergency accommodation beds which could be provided for patients, involvement with the Out of Hospital services and engagement with the Quality and Outcomes Framework programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider did not have effective systems in place for non-clinical staff to receive formal training in safeguarding and basic life support. Training, learning and development needs of individual staff members must be carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role. Regulation 18, (2) (a)