Great Chapel Street Medical Centre

Quality Report

13 Great Chapel Street,
London,
Greater London,
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Date of inspection visit: 11 January 2018
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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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

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. The overall rating for the practice was good with safe as requires improvement and responsive as outstanding. The full comprehensive report on the May 2015 inspection can be found by selecting the 'all reports' link for Great Chapel Street Medical Centre on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection carried out on 11 January 2018 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 19 May 2015. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

The previous issues were;

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

Overall the practice is rated as good.

Our key findings were as follows:

The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- Staff who acted as chaperones were trained for the role and had received a DBS check, and posters advertising this were in the waiting room and consulting rooms.
- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received training in basic life support and fire safety.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

Summary of findings

- The waiting room was in need of decorating and the flooring needed replacing.

We saw several 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 outreach service led to the development of the Integrated Care Network (ICN) which has been adopted by the local authority and CCG. The purpose of the pathway was to intervene medically and socially to prevent the deterioration of medical or mental health conditions that might have led to a hospital admission.
- 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.

The areas where the provider should make improvements are:

- Review the arrangements for staff appraisals to ensure that all staff receive them annually.

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

Summary of findings

The six population groups and what we found

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

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

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 GP specialist adviser and an expert by experience.

Background to Great Chapel Street Medical Centre

Great Chapel Street Medical Centre is a specialist practice for homeless people living in Westminster. As a result their patient population is very different from the average general practice. 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 NHS Central London (Westminster) CCG area.

Their address is : 13 Great Chapel Street, London, W1F 8FL,

Website; www.greatchapelst.org.uk

The practice team is made up of four GPs (three male, one female) providing 10 sessions per week, two nurses providing 14 sessions, a practice manager, a primary care manager/social advocacy worker, and a reception manager.

The practice opening hours are between 9am to 5pm, 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.

Additional services provided by the practice are;

Sexual Health & Hepatitis C Clinics - Last Friday of the month 1.30-3.30;

Smoking Cessation Clinic - Drop in Fridays 10-12;

Social Advocacy - Housing advice, Benefits advice and related issues; advice, advocacy and referrals. Daily drop in and by appointment;

Podiatry - Friday mornings from 9-12.30;

Dentist - Tuesday & Thursday by appointment only.

The practice population is transient and relatively small in number currently the patient list size is 624, the male to female ratio is 3:1 and the median age is around 40. The practice does not register children.

The population is ethnically very diverse and includes a large proportion of EU migrants and refugees. The vast majority of their patients are unemployed and on benefits. Many have no recourse to public funds and are destitute.

Good

Are services safe?

Our findings

At our previous inspection on 19 May 2015, we rated the practice as requires improvement for providing safe services, as not all non-clinical staff had received safeguarding or basic life support training.

These arrangements had significantly improved when we undertook a follow up inspection on 11 January 2018. The practice is rated as good for providing safe services.

We rated the practice, and the relevant population groups, as good for providing safe services.

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had effective systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment, with weekly and monthly multi-disciplinary-team (MDT) meetings.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

Good

Are services safe?

- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines were possible.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, the practice had had five significant events in the last 12 months two of these had been an aggressive incidents involving intoxicated patients, staff were reminded of the practice's strict rules on alcohol consumption in the clinic and refusal to see anyone who was intoxicated.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 19 May 2015, we rated the practice as good for providing effective services.

These arrangements had been maintained when we undertook a follow up inspection on 11 January 2018.

The practice is rated as good for providing effective services.

Effective needs assessment, care and treatment

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

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

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 make them vulnerable: Good

- End of life care was delivered in a coordinated way which took into account the needs of those whose 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 find it difficult to engage with health and social care providers.
- The Social Advocacy Worker was available five days a week to provide patients with housing, benefits, employment advice and 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 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.
- 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.

Monitoring care and treatment

Due to the uniqueness of the practice, and the very small number of registered patients, the practice does not participate in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). Staff explained that because of the transient nature of their patients it was difficult to monitor outcomes.

As part of their contract the practice were able to measure their performance against set key clinical indicators such as;

- 63% (10 out of 16) of patients with asthma had received a review in the last 12 months, the NHS England (NHSE) target was 70%.
- 96% (241 out of 255) of patients who had high blood pressure had had a reading in the last 5 years, the NHSE target was 90%.

Good

Are services effective?

(for example, treatment is effective)

- The percentage of patients who had diabetes and had a blood pressure reading of 140/80 or less was 73% (22 out of 30) the NHSE target was 78%.

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. This had been developed and added to since the practice was set up in 1975 adding services such as psychiatry, dentistry and social services where they opportunistically saw patients when they walked in and if the GP was busy. 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 three clinical audits completed in the last year, one of which related to the high non-attendance (DNA) rate at outpatient clinics. The practice wanted to understand and reduce the number of non-attendances and did a count of how many they had in the previous year. They then analysed the patient demographics, to determine the overall DNA rate (10%), the 'top 5' patients in this category and an analysis of each patient making recommendations for action. Changes made after this first cycle included agreeing an administration protocol to ensure data quality and up to date patient contact details (significant in their patient population), the greater use of a peer support service who would accompany patients to appointments and liaising with the clinical team of outpatient clinics for whom their patients attendance rates were particularly poor to remove system barriers if possible. The second cycle, 13 months later, showed that DNA rates had been reduced to 7% below the national average of 8%, and that the measures actioned had positively affected outpatient attendance.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, coaching and mentoring, clinical supervision and support for revalidation, however some of the staff were two months their appraisals. The induction process for healthcare assistants included the requirements of the Care Certificate (The Care Certificate was officially launched in March 2015. It aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care). The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- The practice was supported by and collaborated 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 in order to achieve this.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Staff providing the outreach service also worked closely with A&E departments and 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.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

Good

Are services effective?

(for example, treatment is effective)

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

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

At our previous inspection on 19 May 2015, we rated the practice as good for providing caring services.

These arrangements had been maintained when we undertook a follow up inspection on 11 January 2018.

The practice is rated as good for providing effective caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 36 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Of the 304 surveys sent out, 17 were returned. This represented about 3% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 90%.
- 94% of patients who responded said the GP gave them enough time; CCG - 82%; national average - 88%.
- 100% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 94%; national average - 96%.
- 88% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 82%; national average - 87%.
- 100% of patients who responded said the nurse was good at listening to them; (CCG) - 87%; national average - 92%.
- 94% of patients who responded said the nurse gave them enough time; CCG - 88%; national average - 93%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 96%; national average - 98%.
- 93% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 87%; national average - 92%.
- 94% of patients who responded said they found the receptionists at the practice helpful; CCG - 87%; national average - 90%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

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 higher than local and national averages:

- 100% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 84% and the national average of 88%.
- 87% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 79%; national average - 84%.

Good

Are services caring?

- 100% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 80%; national average - 87%.
- 100% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 80%; national average – 87%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 19 May 2015, we rated the practice as outstanding for providing responsive services.

These arrangements had been maintained and built upon when we undertook a follow up inspection on 11 January 2018.

The practice is rated as outstanding for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example offering walk in services for dentistry, podiatry, offering social advocacy were all added to the service as a direct result of this patient group's identified need.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- 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, alcohol, substance misuse 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 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. Patients were able to access shower facilities and clean clothes on request at the practice.

People whose circumstances make them vulnerable:

- 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 25% of all rough sleepers in England and Wales 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 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. This service had been expanded to include Homeless Health Service, a team of community nurses based in homeless day centres and the senior practice nurse held a weekly session at a vulnerable women's day centre in the area. The centre was a women only space and had a significant group of homeless vulnerable migrant women. It was chosen in response to concerns about a lack of smear uptake, an increase in rates of unwanted pregnancy in this population and concerns about exploitation of this vulnerable group of women.

The outreach service led to the development of the Integrated Care Network (ICN) which has been adopted by the local authority and CCG. The ICN is an organised network providing intermediate health care to the homeless population in Westminster, the network worked with the homeless health services and hospitals in the borough. The network began in October 2015 and was officially launched in June 2016. The ICN team accepted referrals from GP's and hospitals, once a patient was referred they were given a hostel bed for six weeks whilst their health care needs were met, the ICN team provide a 'wraparound package' which addressed health and homelessness needs.

- 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.

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- 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 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.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The walk-in service did not require pre-booked appointments, but they were available for patients who needed longer appointments.
- The average appointment length was 17 minutes.
- Patients with the most urgent needs had their care and treatment prioritised.
- The medical centre was open between 9am and 5pm Monday to Friday.
- GP appointments were available from 11am-12:30pm on Monday, Tuesday and Thursdays and 2pm-4:30pm daily. Nursing appointments were available from 10am-12:30pm and 2pm-4:30pm daily.
- Patients could access housing, benefits and employment advice and support daily via the Social Advocacy Housing Advisor Worker.
- Patients could access drug and alcohol advice with the Mental Health nurse from 10am-12:30pm and 2pm-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 9am-12:30pm.
- Psychiatry appointments were available for patients by appointment on Tuesday's between 11am-1pm and 2pm-4:30pm.
- A counselling service was provided as a drop-in session on Mondays between 10am-12pm and 2pm-4:30pm on Thursdays and by appointment on Wednesdays 10am-4:30pm.

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.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. There were 304 surveys sent out and 17 were returned. This represented about 3% of the practice population.

- 81% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 79%.
- 87% of patients who responded said they could get through easily to the practice by phone; CCG – 84%; national average - 75%.
- 94% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 84%; national average - 87%.
- 87% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 84%.
- 88% of patients who responded described their experience of making an appointment as good; CCG - 75%; national average - 77%.
- 25% of patients who responded said they don't normally have to wait too long to be seen; CCG - 59%; national average - 67%.

Results from the practice patient survey from May 2017 to November 2017 showed that patients were generally satisfied with the practice and the service they received. For example:

- 89% (81 of 88) of patients asked said they would recommend this surgery to someone new in the area.

Listening and learning from concerns and complaints

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Four complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, when a patient submitted a written complaint regarding a referral that had not being sent, the practice checked their systems and found that the fax they had sent had not been received, they quickly contacted the recipient and submitted it. They changed their process which now included a received receipt and telephone confirmation. The patient received a written apology.

Are services well-led?

Good

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

Our findings

At our previous inspection on 19 May 2015, we rated the practice as good for providing well-led services.

These arrangements had been maintained when we undertook a follow up inspection on 11 January 2018.

The practice is rated as good for providing well-led services.

Leadership capacity and capability

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

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

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with commissioners, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Not all staff had received their annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

Are services well-led?

Good

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

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example as a result of patient and PPG suggestions the waiting area had been improved with the addition of TV screen, more information about services available was signposted and confidentiality at the reception desk was improved.
- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice had expanded their involvement in the training of medical students in the area of health inclusion. The GP delivered lectures and tutorial on the final year Speciality Choice module – Health Inequalities. Additionally, the lead GP had been the Designated Medical Practitioner for two of the nurses in the Homeless Health Service during their non-medical prescribing course. The practice also provided training and education to local organisations such as the Salvation Army and local hostels.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The practice were a part of the Integrated Care Network (ICN), the ICN is an organised network providing intermediate health care to the homeless population in Westminster.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.