

Dr Kenyon & Partners

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?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

Summary of findings

Contents

Summary of this inspection

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

Detailed findings from this inspection

Our inspection team	10
Background to Dr Kenyon & Partners	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Kenyon and Partners on 27 August 2015. This inspection covered areas of concern we identified at our last inspection in July 2014 regarding cleanliness and maintenance of the premises as well as identifying and responding to risk. We found the practice had addressed these concerns.

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.
- Risks to patients were assessed and well managed.
- Staff recruitment, training and support ensured they were safe and able to fulfil their roles.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice was clean and well maintained.
- There was monitoring of patient care but this was not in the form of a programme of clinical audit including repetition and completion of audits to ensure improvements to the service were made.
- Some data regarding medicine reviews suggested clinical assurance could be improved.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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 several areas of outstanding practice including:

- Nurse support was supplemented with six weekly clinical supervision sessions led by an external clinical facilitator. This provided additional support beyond the regular training and supervision for nurses in this practice.

- It was policy for a patient's who were reaching the end of their life and choosing to die at home to have their GP provide a family or carer with a personal contact number so that contact out of hours could be made if necessary.

Additionally there was one area the practice should make improvements:

- Monitor data related to medication reviews to ensure that patients who require medications reviews receive these.

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?

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

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were similar to average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. However, some data suggested that medicine reviews were not taking place within recommended timeframes. 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.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and survey data placed the practice at or above the local and national average for access. Named GP appointments were available and patient feedback suggested access to these was better when compared to the other local practices and against national data. There was continuity of care, with urgent appointments available the same

Good



Summary of findings

day. 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 evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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. The practice was planning for the provision of its services in the future and was participating in a vision for the future of the local healthcare economy.

Good



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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and participated in schemes to promote diagnosis of conditions often associated with aging such as dementia. Home clinics were offered to patients who needed health checks but found it difficult to attend the practice. Responsive home visits and rapid access appointments were also available.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority, and proactively case managed. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. However, some data suggested that medicine reviews were not taking place within recommended timeframes. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The home visit clinics were also available to patients who found it difficult to attend the practice but required periodic health checks.

Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were similar to the national average for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this population group had been identified and the practice had adjusted

Summary of findings

the services it offered to ensure these were accessible, flexible and offered continuity of care. Online booking had been offered and 733 (5%) patients had registered for the service. The practice was proactive in offering telephone appointments and follow up information or consultations with patients via email. There were three extended hours sessions per week, including Saturday mornings. The practice registered approximately 6,000 students. Staff attended local university colleges to register patients and provide advice about accessing local health services. Same day access was offered to students.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. They offered annual health checks for people with a learning disability. Longer appointments were offered for people with a learning disability. The practice worked with and registered patients at local homeless and probation hostels. Homeless patients were registered with the practice without the need of a fixed address. A benefits adviser attended to support patients regularly.

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. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Data suggested there was a high uptake of health checks for patients suffering from poor mental health, including 100% annual blood testing for patients with psychosis. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out a scheme to improve the diagnosis of dementia and advance care planning for patients with dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The most recent national GP patient survey results showed the practice was performing in line with local and national averages. There were 103 responses and a response rate of 22%.

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 86% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81%
- 92% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 89% said the GP gave them enough time which is the same as the CCG average and higher than the national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%
- 91% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

- 82% patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.
- 75% of patients were satisfied with the practice's opening hours which matched the local and national averages
- 88% found it easy to contact the surgery by phone compared to the CCG average of 83% and national average of 73%.
- 88% patients described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.
- 65% patients said they usually waited 15 minutes or less after their appointment time which matched the national and local average.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all positive about the standard of care received. Patients frequently referred to the services they received as excellent and caring. Patients we spoke with consistently provided positive feedback.

Areas for improvement

Action the service **SHOULD** take to improve

Monitor data related to medication reviews to ensure that patients who require medications reviews receive these.

Outstanding practice

- Nurse support was supplemented with six weekly clinical supervision sessions led by an external clinical facilitator. This provided additional support beyond the regular training and supervision for nurses in this practice.
- It was policy for a patient's who were reaching the end of their life and choosing to die at home to have their GP provide a family or carer with a personal contact number so that contact out of hours could be made if necessary.

Dr Kenyon & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist adviser, a CQC inspection manager, a practice nurse specialist adviser and an Expert by Experience.

Background to Dr Kenyon & Partners

The practice was located in a converted Georgian building in Oxford city centre. The proximity to Oxford University colleges meant that the practice had a very high proportion of students, approximately 6,000 and a higher proportion of patients aged 20-29. The local area has a mix of affluent professionals and also a social housing estate, and the practice population is placed in the sixth least deprived decile overall in national data. There was disabled access and the ability to see patients with limited mobility on the ground floor. Nurses' treatment rooms were located on the ground floor.

Ten partners work at the practice with five male and five female GPs. The nursing team consisted of practice nurses and health care assistants. There were also a physiotherapist, addictions nurses and midwife working providing services onsite. The practice has a General Medical Services contract (GMS). These contracts are negotiated directly between the General Practice Committee and the provider, via NHS England. This is a training practice and there was a trainee working at the practice at the time of the inspection.

The practice is open between 8am and 6pm for appointments and phone lines are open until 6.30pm Monday to Friday. Extended hours surgeries were offered until 8.10pm Tuesdays and Thursdays and on Saturdays between 8.30am and 12pm.

There were arrangements in place for patients to access emergency care from an Out of Hours provider. This inspection covered areas of concern we identified at our last inspection in July 2014 regarding cleanliness and maintenance of the premises as well as identifying and responding to risk. We found the practice had addressed these concerns.

Dr Kenyon and Partners is registered to provide services from the following location 19 Beaumont Street, Oxford, Oxfordshire.

The practice is meeting its condition to have a registered manager in post.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This practice had not been rated under the new methodology of inspection and this is why we carried out a comprehensive inspection.

We carried out a comprehensive inspection in July 2014, using the previous methodology, and published a report setting out our judgements. We asked the provider to send a report of the changes they would make to comply with the regulation they were not meeting. Therefore, the current inspection ensured we followed up on the areas of concern from the last inspection.

Detailed findings

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

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

- Older people
- People with long-term conditions
- Families, children and young people

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other stakeholders to share what they knew, such as the local clinical commissioning group. We carried out an announced visit on 27 August 2015. During our visit we spoke with a range of staff including GPs, nurses, receptionists and the practice manager and spoke with patients who used the service. We observed how people were being cared for and looked at documentation related to the services provided and the management of the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record and learning

There was an open, transparent approach and a system in place for reporting and recording significant events. Staff were able to report incidents and learning outcomes from significant events were shared with appropriate staff. All complaints received by the practice were entered onto the system and where necessary treated as a significant event. Meetings were held every three months to discuss significant events that had been raised, or during other staff meetings if the issues raised needed prompt action. The practice reviewed previous significant events at the meetings to ensure changes or learning outcomes had become embedded. We looked at several significant events and saw that appropriate action was noted.

Safety alerts (including medicine and equipment alerts) were monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled the practice to communicate and act on risks and gave a clear, accurate and current picture of safety.

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 and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. Only nursing staff acted as chaperones and were trained for the role and had received a disclosure and barring 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 and related risk assessments. The practice had undertaken a fire risk assessment in 2013 and we saw actions required from the assessment had been completed. This included improvements to make existing fire doors resistant to smoke and installing fire doors where needed. Regular 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. We saw actions related to the legionella risk assessment were undertaken.
- Appropriate standards of cleanliness and hygiene were followed. At our last inspection in July 2014 we found the clinical treatment rooms and some communal areas were poorly maintained and in need of repair to enable them to be cleaned appropriately. At this inspection we observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead and they undertook audits to ensure infection control processes were followed. The infection control lead did not have advanced training to perform this role training had been booked on a course with a clinical commissioning group infection control lead in September 2015. There was an infection control protocol in place and staff had received up to date training. Monthly meetings with a cleaning contractor took place to discuss any concerns regarding cleanliness. A sharps or needle stick injury protocol was available for staff.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out every two to three months with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing.

Are services safe?

Prescription pads were securely stored and there were systems in place to monitor their use. Vaccines were stored appropriately and audited. Controlled drugs were securely stored on site and there were appropriate processes for receiving and administering them. Nurses administered vaccines and injections with authorisation from approved prescribers via patient group directives.

- A recruitment policy was in place and we checked six files which showed that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. There were notes that employee identification had been checked in some of the staff files but not all had a record of identification checks. When we asked the practice manager about which forms of identify were used they confirmed that they looked at smart cards (a card required for accessing patient computer records) when recruiting clinical staff as acquiring these cards required robust identification checks.

Arrangements to deal with emergencies and major incidents

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. This was accessible to senior staff including the practice manager externally should the practice and its computer system be inaccessible.

Clinical staff received annual basic life support training. However, the practice had identified a need for reception staff to receive this training as there were occasions when a GP worked onsite alone with only reception staff. Receptionists were due to receive the training in November 2015. There were emergency medicines and equipment available including an automated external defibrillator (AED) and oxygen. 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. We saw that the medicines were locked away and accessible by locating three separately secured keys. This could delay the access to these drugs in an emergency. We informed the practice of this issue and GP partners told us they would improve the accessibility of the drugs immediately. The practice did not store a drug required in the event of an opiate overdose. As the practice cares for patients at potential risk of such an overdose and therefore this drug may be required.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The practice had systems to ensure daily tasks were undertaken by appropriate staff. This included computer storage for documents related to discharge summaries and out of hours correspondence. They were allocated to GPs for any action to be taken. This enabled GPs to access their tasks easily. There was also a system for allocating test results. Most GPs at the practice were part time and we were told there was sometimes a delay in completing and filing away test results. GPs told us there was a system for any urgent test results to be communicated to them quickly and directly from laboratories where there was deemed to be a potential risk to patients. There was also oversight to test results by an administration member of staff who would be able to identify any results flagged as urgent. If any results were deemed urgent and needed attention in a GPs absence, these would be passed to the duty GP for action. On the day of inspection there were 119 outstanding test results, most one to two days old. GPs explained that six results older than this had been reviewed by a GP but had not yet been actioned or stored on patients records because they were not urgent.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In 2015 98% of the total number of points available were achieved. In 2014 exception reporting was similar to the national average but significantly higher for diabetes indicators. This practice was not an outlier for any QOF (or other national) clinical targets.

- Performance for diabetes related indicators was 98% but in 2014 the exception reporting diabetes indicators was 14% compared to the national average of 10%. We asked GPs why this was high and they suggested reasons such as the transient nature of their population and hard to reach groups such as homeless patients. There had not been a check of exception reporting via audit to identify if the exception reporting was high for these reasons.
- Hypertension QOF indicators for 2015 were 100%. Blood tests for patients with specific mental health conditions were reported as 100% in the last year. Also 87% of patients with a reported mental illness had their blood pressure checked with the national average in 2014 at 83%.
- The dementia diagnosis rate was above the national. The practice had undertaken a local incentive scheme to identify any potential patients with dementia who had not received a diagnosis.

Some clinical audits were carried out to demonstrate quality improvement. For example, a Parkinson's audit had been completed to identify patients who would benefit from physiotherapy and seven patients undertook physiotherapy as a result. This audit was prompted by new research findings which were reviewed and acted on by GPs. There were audits prompted by the clinical commissioning group, such as pharmacy audits. However, there was no overall programme of audit which identified when audits would be completed and for staff to access in a central location as a learning resource. Audits were not routinely discussed with nurses. We noted some areas of clinical care where audits could have identified potential areas of improvement and action. For example, one clinical audit led to 100% of patients on 10 medicines or more receiving medicine reviews in the last year. However, data provided to us on patients on four or more medicines, suggested the figure for completed medicine reviews was 68% and for patients with less than four repeat medicines the figure was 46%. GPs told us that patients with long term conditions were written to three times and followed up with a phone call, when necessary, when they needed their periodic reviews of their conditions. This would usually prompt a medicine review when required. GPs told us that coding patients appropriately on their system was challenging due to the high numbers of new student registrations each year. There had not been any check, through auditing patient records, to identify whether the

Are services effective?

(for example, treatment is effective)

low figures for patients on less than 10 repeat medicines was caused by recording issues or clinical management of the patients. Therefore the practice was not assured that these patients were offered the appropriate reviews of their medicines when necessary.

We looked at audits on dermatology and use of referrals for specific conditions. These audits were from 2013 or 2014. There was no evidence of repetition of the audits to complete the loop and identify where improvements had been made as a result.

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: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.
- Nurses attended external clinical supervision every six weeks from an external facilitator in addition to their external training courses. This provided additional support beyond the regular training and supervision for nurses in this practice.

Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. The practice had identified 292 patients who were deemed at risk of admissions and care plans had been created to reduce the risk of these patients needing admission to hospital. A monthly meeting was held to discuss patients discharged from hospital and was attended by GPs and nurses. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated.

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 (MCA). Staff had access to an MCA protocol. 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.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients receiving end of life care, carers, homeless patients and smoking cessation. Patients were signposted to relevant external services where necessary service such as a local smoking cessation service.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 76% which was slightly below the national target of 80%. However, the practice registered many foreign nationals and students which may have impacted on this figure and it was often difficult to exempt patients who were eligible but not taking the practice's screening service. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend

Are services effective?

(for example, treatment is effective)

national screening programmes for bowel and breast cancer screening. In total 240 patients had undertaken bowel cancer screening and 629 patients had been screened for breast cancer.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. In 2015 the overall vaccination rates for children were approximately 88%. Flu vaccination rates for at risk groups including over 65s was 66% in 2015, which is slightly below the 2014 national average.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. The practice provided well-woman clinics specifically for the women's health needs. Patients from local homeless and probation hostels were offered health checks.

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.

All of the 13 patient CQC comment cards we received were positive about the service experienced. All 11 patients we spoke with said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with a member of the patient participation group (PPG) on the day of our inspection. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was close to or above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 89% said the GP gave them enough time which is the same as the CCG average and higher than the national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%
- 91% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.
- 82% patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

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

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 86% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice website also listed a number of services including counselling and a local disability advisory service.

The practice's computer system alerted GPs if a patient was also a carer. This enabled staff to consider and respond to these patients' needs. Bereavement support was offered via a local counselling service.

Staff told us that if families had suffered bereavement, their usual GP contacted them. A GP told us that when patients were reaching end of life and required close monitoring, it was policy for the patient's specific GP to provide a family or carer with their personal number so that contact out of hours could be made if necessary. This was confirmed by feedback from a comment card we received.

Are services caring?

A benefits adviser attended the practice regularly. This enabled patients to seek advice from the adviser in regards to any support they may require regarding benefit claims, such as incapacity benefit.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. The practice had a very high population of students registered from the local University, approximately 6,000 patients. The practice also cared for local probation and homeless hostels. Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice offered home clinics to older patients or those with chronic conditions who found it difficult to attend the practice. This meant patients with health conditions could have nurse led health checks in their homes when needed.
- There were longer appointments available for people with a learning disability.
- The ability to see a named GP was something patients valued at the practice, with 78% of patients saying they could see their preferred GP on the national survey compared to 68% locally and 60% nationally.
- There was disabled access, a hearing aid loop and translation services available. However, the premises were a converted Georgian building and this limited disabled access to the ground floor. No disability discrimination act assessment had been undertaken to determine if any further improvements could be made to the service.
- The practice provided 12 minute routine appointments compared to the minimum 10 minute appointments provided in most GP practices.
- Due to the large student population, staff visited the University's colleges during fresher's week each year (when new students attend their places of study). GPs said this was in order to assist patients to register with a GP and to inform foreign students of how the NHS provides care and that it is free at the point of access.
- For patients resident in probation hostels, GPs stated they liaised with prison healthcare services as patients in these hostels are temporary but the service wanted to provide a continuity of care.

- The practice has many patients who work full time and many who commute outside of Oxford. Therefore the practice provides email correspondence where this appropriate, for follow ups to test results or consultations.
- The practice staff were aware that some of its patient population is classed as deprived and there was consideration regarding this this section of the population.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available until 6pm other than when extended hours surgeries were offered. These were until 8.10 pm Tuesdays and Thursdays and on Saturdays between 8.30am and 12pm. In addition to pre-bookable appointments that could be booked in advance, same day appointments were made available daily and urgent appointments were also available through a system of triage. For urgent appointments, patients were often called back by a GP to determine whether they needed to see a GP, nurse or if their needs could be met by a different service such as a pharmacist.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable or better than local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 75% of patients were satisfied with the practice's opening hours which matched the local and national averages
- 88% found it easy to contact the surgery by phone compared to the CCG average of 83% and national average of 73%.
- 88% patients described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.
- 65% patients said they usually waited 15 minutes or less after their appointment time which matched the national and local average.

The practice had audited its appointment system and changed the system as a result. The audit had identified peak times when additional demand was required specifically for GP appointments. This had led providing more appointments during these times.

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

We saw that information was available to help patients make a complaint or comment on the service they

received, through the website and in the practice itself.

There was no policy or process information for patients to understand what would happen once they made a complaint. We looked at three complaints received in the last two years and found that complaints were investigated and responded to. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, we saw complaints had led to significant event analysis taking place.

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 deliver high quality care and promote good outcomes for patients. This vision included the need for equal access and the best use of limited resources. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. Training was a fundamental feature of the practice's strategy and staff felt well supported in this regard when we discussed their personal development with 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
- A comprehensive understanding of the performance of the practice
- Some audits were undertaken to monitor quality and to make improvements but no overall programme was in place. Data indicated that medicine reviews were not always being completed when needed or recorded. There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Regular meetings took place for staff groups including whole staff, nurse, partner, clinical governance and reception and administration staff meetings.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. There was a priority for providing safe, high quality and compassionate care among all staff. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The partners encouraged a culture of openness and honesty and this was reflected in the reporting of incidents and feedback provided through appraisals.

Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. The practice manager also told us that team away days were held every year which were informal and a means for staff to socialise outside of the normal working environment. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop 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. Feedback was received through comments and the friends and family test. This feedback had prompted an audit into the appointment system and led to changes to improve waiting times. Feedback had also been gathered through the patient participation group (PPG) and through complaints received. There was an active PPG which met on a regular basis, and a report of actions agreed by the PPG had been put in place. This included improvements to the physical environment, such as redecoration where required.

The practice had also gathered feedback from staff through staff meetings and appraisals. We saw that appraisals from December 2014 had identified that staff felt communication could be improved in the practice. We noted during the inspection that short daily meetings took place between all staff at a morning coffee break.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and had considered the provision of care in the local area as well as the need to move premises. The practice was leading a bid to move to a centralised location for a health centre including multiple general practices in Oxford. The partnership had successfully won a bid to put forward the model and business case for the centralised location. The potential benefit to the local community would be a centralised health centre providing a variety of services from purpose built premises.