Luther Street

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Outstanding
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

Luther Street provides primary health care services for homeless people over the age of 16 and people vulnerably housed in Oxford. It is based in a purpose built medical centre and provides services to five hostels in the City of Oxford. The service is actively involved with a range of voluntary and statutory organisations in the area to provide co-ordinated care to this vulnerable patient group. The service is available to patients who find it difficult to register with general practice and as a consequence would not access care and treatment they require.

The service is part of Oxford NHS Foundation Trust and works closely with Oxford Homeless Pathways (an organisation providing hostels and other services for the homeless). The practice provides training opportunities for both GPs and nurses from local universities. The four GPs working at the practice are supported by a practice manager and a team of specialist staff including a specialist addiction practitioner and mental health practitioners. Additional services including podiatry and dentistry are available at the practice.

We carried out a comprehensive inspection on 30 September 2015. We spoke with patients, a member of the patient participation group and staff including the management team. The inspection focussed on whether the care and treatment of patients was safe, effective, caring, responsive and well led.

Overall the practice is rated as good. It was outstanding for provision of caring and responsive services. Good for effective and well led services and requires improvement for delivery of safe services. The practice was rated outstanding for provision of services to two of the six population groups. We did not apply ratings to the population group of older people. This was due to the practice only having 2 patients registered over the age of 75.

Summary of findings

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from significant events and incidents by attendance at the daily team meetings.
- There were systems in place to keep patients safe from the risk and spread of infection.
- The practice was responsive to the differing needs of its patient population.
- We saw that staff were able to identify and respond to the changing risks of patients, this included deteriorating health and well-being or the need to refer to other services.
- Patients were treated with compassion, dignity and respect.
- The practice has a clear ethos to improve the health of vulnerable and excluded groups.
- There was a culture of learning and development.
- Innovative approaches were used to improve patient health.

We saw several areas of outstanding practice including:

- Provision of volunteer support to patients attending hospital appointments and appointments with other services. This meant patients who might not attend appointments were assisted to do so.
- All patients receive a comprehensive health check when they first register with the practice. Patients health and social care needs were therefore identified at an early stage and services established to meet these needs.
- Visiting homeless patients in remote locations, which other services would find difficult to do, to deliver care and treatment. Patients in these circumstances would otherwise have gone without care and support they needed.
- The practice involves homeless patients in the delivery of services via an award winning patient participation group and undertakes patient surveys. Action is taken to adjust service delivery in response to patient feedback.
- Innovative treatment regimes are employed. For example alcohol reduction programmes that do not involve medicines. Research shows this treatment programme to be both effective and reduces risks associated with medicines.
- Daily team meetings took place where all staff were involved in planning care and treatment ensuring a co-ordinated approach to meeting patients care and treatment needs.

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

Importantly, the provider must:

- Ensure all staff are trained in basic life support.

In addition the provider should:

- Promote the availability of the chaperone service.
- Ensure nurses who administer medicines included in Patient Group Directions receive updated training in the administration of these medicines. (Patient Group Directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment)

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Processes and equipment to deal with emergencies should be improved. Reception and administration staff had not been trained in basic life support. Nurses had not received update training in administration of medicines covered by PGD's.

However, staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed positive patient outcomes for the patient group served. We did not apply a comparison of data with non-specialist GP practices because of the transient registered population and in recognition of their complex needs. Staff referred to guidance from the National Institute for Health and Care Excellence and other sources 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. Staff had received most training appropriate to their roles and any further training needs had been identified and training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and co-ordinated care with many local organisations.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Feedback from surveys and the patients we spoke with rated the practice highly for almost all aspects of care. Patients were strongly positive about the care and treatment they received. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked as a team to overcome obstacles to achieving this. We found many positive examples to demonstrate how staff respected a patients' homeless status and went out of their way to provide the care and treatment needed. For example, working with patients who chose not to attend the practice had encouraged take up of important care and treatment and also resulted in a patient taking a place at a local hostel. Patients reported a high level of involvement in planning their care

Summary of findings

and care plans we saw reflected this. Care was planned to meet both health and social care needs of the patient and other agencies were involved to ensure care needs identified were met. Views of external stakeholders, for example Oxford Homeless Pathways and National Association of Patient Participation, were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding ☆

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

Services had been expanded for example, podiatry and dentistry were provided. This made these services more accessible to homeless people who would be unlikely to attend such services if they were at a variety of locations. Patients reported excellent access to the practice with face to face appointments always available on the day requested. 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. There was a system in place to respond to complaints and to share any complaints with the practice team and the provider.

Are services well-led?

Good ●

The practice is rated as good for being well-led. It had a strong patient centred ethos which placed quality and safety as its top priority. High standards were promoted and owned by all practice staff and the practice team demonstrated a cohesive approach to delivery of care. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and had won a highly commended award in 2014 for the work of its patient participation group (PPG) which influenced practice development.

Summary of findings

The six population groups and what we found

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

Older people

There was not sufficient evidence to provide a rating for this population group. There were only two patients in this population group registered at the time of inspection.

Not sufficient evidence to rate

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. Data showed the care of this group of patients was regularly reviewed and performance in achieving annual health reviews was high when taking account of the difficult to reach patient group. The care of all patients discharged from hospital was reviewed and treatment adjusted to reduce the risk of further admission. Disease registers were held and these were subject to monthly review and update by the GPs and practice nurses. Longer appointments and home visits were available when needed. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good

Families, children and young people

The practice does not register patients under the age of 16. When a registered patient has a child the care of the family is undertaken by a non specialist GP practice.

Homeless people aged 16 to 18 were able to register with the practice. They received a comprehensive health check when they registered. Parents who were homeless could register with the practice and the practice assisted them with advice and support to both manage their own health needs and co-ordinate contact with their children. If a person aged under 16 tried to register with the practice they were referred to social services or to their previously registered GP practice. There were systems in place to alert the safeguarding authorities and we were given examples of when this system had been employed.

Good

Working age people (including those recently retired and students)

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The majority of patients registered were of working age. The practice provided a range of services for this group including benefits and housing

Outstanding

advice. Support was given to those patients seeking to take up work. Both walk in and booked appointments were available each weekday. The practice offered a range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. All patients registered with the practice were included in this patient group. Everyone who registered received a comprehensive health check when they first registered. Those identified with long term health problems were placed on disease registers that were reviewed and updated every month. All appointments at the practice were a minimum of 20 minutes which recognised the more complex needs of the patient group.

Referral rates to hospital for appointments were above average compared to the local clinical commissioning group (CCG) but the patients were high demand, homeless people with complex physical and psychological problems. The practice was aware that do not attend (DNA) rates had been above average compared to the local CCG. The patient access to health scheme provided a volunteer to take patients for hospital appointments and this had reduced the DNA rate.

The practice held a register of patients living in vulnerable circumstances including homeless people, refugees and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

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)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). All patients received a comprehensive physical and mental health

check when they first registered with the practice. Care plans were in place for patients experiencing poor mental health. The practice held a register of these patients and we saw that the register was reviewed on a monthly basis.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. There were also examples of how the practice worked closely with the local community mental health team and used the expertise of the consultant psychiatrist who visited once a month. The practice monitored repeat prescribing for patients receiving medication for mental health needs.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. 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. A specialist substance misuse worker and mental health workers were available at the practice and the team were active in providing services for patients who were substance misusers.

Summary of findings

What people who use the service say

The constant turnover of patients meant that participation in the national patient survey was not possible. However, the practice commissioned an independent organisation to carry out a survey in December 2014. There were results from patients taking part in the friends and family survey and an active patient participation group worked alongside the practice.

Engaging the homeless vulnerable group of patients in care has been recognised as difficult yet the practice made significant efforts to do so and actively sought patient feedback. We noted that 46 patients took part in a practice patient satisfaction survey in December 2014 and they were consistently positive about the service they received. For example:

- 100% of the patients were positive that the GPs were good at listening to them.
- 97% said the GP put them at ease.
- 100% said the practice nurses gave them enough time.
- 98% said the practice nurses listened carefully to what they said.
- 91% said the care they received was either good or excellent.
- 91% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 89% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. Patients we spoke with and the comment card we received were very positive about the care and treatment offered by the GPs and nurses at the practice, which met their needs. They said staff treated them with dignity and their privacy was respected. They also said they appreciated the easy access to appointments via the morning turn up for an appointment service.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff are trained in basic life support.

Action the service SHOULD take to improve

- Promote the availability of the chaperone service.
- Ensure nurses who administer medicines included in Patient Group Directions receive updated training in the administration of these medicines. (Patient Group Directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment)

Outstanding practice

- Provision of volunteer support to patients attending hospital appointments and appointments with other services. This meant patients who might not attend appointments were assisted to do so.
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- Visiting homeless patients in remote locations, which other services would find difficult to do, to deliver care and treatment. Patients in these circumstances would otherwise have gone without care and support they needed.
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Summary of findings

- Innovative treatment regimes are employed. For example alcohol reduction programmes that do not involve medicines. Research shows this treatment programme to be both effective and reduces risks associated with medicines.
- Daily team meetings took place where all staff were involved in planning care and treatment ensuring a co-ordinated approach to meeting patients care and treatment needs.

Luther Street

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 advisor, pharmacist advisor and two experts by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Luther Street

Luther Street provides a wide range of care and treatment services to patients who are homeless or vulnerably housed in the City of Oxford. Approximately 900 new patients receive care and treatment each year. At the time of inspection approximately 500 patients were registered with the practice. Due to the circumstances of patients the practice does not retain patients for long periods as they move on to other GP practices, leave the area or their needs change. Patients must be over the age of 16 to register with the service. The practice works closely with a local organisation called Oxford Homeless Pathways (Oxhop). People staying at any one of five local hostels are able to register. The practice is part of Oxford Health NHS Foundation Trust.

Four GPs work at the practice. Three of the GPs are female and one male. One of the GPs is a long term locum covering a male GP on educational leave. There are four practice nurses, two mental health specialist workers and a social practitioner. The clinical staff are supported by a practice manager and a small team of administration and reception staff. The practice benefits from other sessional services including a dentist, addiction nurse specialist, a podiatrist, acupuncturist and a consultant in psychiatry.

The practice is open from 8am to 6.30pm Monday to Friday. Patients can attend without an appointment every morning between 9am and 12.30pm. Booked appointments with the GPs are available between 8am and 9am and appointments are available every afternoon between 2pm and 5pm with both the GPs and nurses. One of the GPs is on-call from 5pm to 6.30pm.

The practice holds a specialist contract for services which is part of the Oxford Health Foundation Trust contract with NHS England. The practice is located within the area covered by NHS Oxford Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

GPs at the practice do not provide out of hours services. When the practice is closed services are provided by Oxford Health Foundation Trust GP out of hours service. A recorded message on the practice telephone system advises patients how to access out of hours services and there is a poster in the practice giving advice to call NHS 111 to obtain advice and support or redirection to out of hours services.

Services are provided from Luther Street Medical Centre, Luther Street, Oxford, Oxfordshire, OX 1 1UL.

Why we carried out this inspection

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

Detailed findings

We carried out a comprehensive inspection of this service on 30 September 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. It formed an integral part of an inspection of Oxford Health NHS Foundation Trust and the practice had not been inspected before.

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

How we carried out this inspection

Prior to the inspection we contacted the Oxfordshire Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Luther Street. We also spent time reviewing information that we hold about this practice including the data provided by the Trust and the practice in advance of the inspection.

The inspection team carried out an announced visit on 30 September 2015. We spoke with eight patients and 11 staff. Comment cards had been available for patients to complete prior to our inspection and one had been completed.

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We held discussions with a range of practice staff including GPs, practice nurses, managers and administration and reception staff.

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)

Data held for the practice was reviewed but due to the specialist nature of the service not all data could be compared to other GP practices.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. Patients affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The practice carried out an analysis of the significant events. We reviewed minutes of meetings that showed us significant events were followed up. The practice team revisited any significant events the month after they occurred to ensure action had been taken based on the learning from the specific incident. Significant events arising at the practice were reported to the NHS trust corporate team. This facilitated trust wide learning from such events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, staff were encouraged to seek health screening following an incident with a patient who had an infectious disease.

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

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. 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.
- If a homeless person under the age of 16 attended to register at the practice they were redirected to their previous GP and social services were alerted.
- A chaperone service was available and staff offered this when appropriate. The availability of the chaperone service was not promoted with any posters in the waiting room. All staff who acted as chaperones 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 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. The practice had up to date fire risk assessments and 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.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be generally clean and tidy although the backs of some chairs in the waiting room were dusty. The senior practice nurse was the infection control clinical lead who liaised with the trust infection control lead to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Prescription pads were securely stored and there were systems in place to monitor their use. The nurses used patient group directions (PGDs) to administer a range of medicines. The Trust updated these PGD's every two years. We saw that nurses had signed the PGDs to confirm they had been trained to administer the medicines. However, the nurses we spoke with told us they would welcome refresher training and we found

that this had not been undertaken in the last four years. There was no record of the competence of nurses to administer the medicines being reviewed during this period.

- The GPs prescribed heroin substitute medicines and there was a system in place to ensure prescriptions were not misused. If a patient reported they had lost their prescription local pharmacies were contacted to check that the prescription had not been dispensed. The patient was required to report the loss to the police and obtain a crime reference number before a further prescription was issued. Arrangements were in place with local pharmacies for the controlled dispensing of these medicines.
- Recruitment checks were carried out and the seven files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. For example, the practice operated a rota that ensured there were always two nurses on duty.
- The practice held a risk register which was reviewed at the monthly team meeting. Any significant risks and safeguarding concerns were discussed at the daily meeting and actions agreed to reduce or mitigate risks. For example, we saw that when patients posed a risk to others they were issued with three warnings before they were referred to the difficult to place patients register and/or the police. CCTV had also been installed in the practice to reduce the risk to both patients and staff.

Arrangements to deal with emergencies and major incidents

There was an alert system in all the consultation and treatment rooms which alerted staff to any emergency. GPs and nurses received annual basic life support training. However, this training was not available to the administration and reception staff. We noted that there were occasions when only a GP and member of reception staff were on duty which meant only the GP was trained to deal with emergencies. The practice manager and lead nurse showed us e-mails in which they had requested basic life support training for reception and admin staff but they had been informed that it was trust policy to only offer this training to clinical staff. There was a risk to both the GPs and patients at the practice because administrative and reception staff had not received training in how to deal with medical emergencies. Subsequent to the inspection we discussed our findings with the provider's senior leadership. They advised us that they would arrange basic life support training for the administration and reception staff at the practice.

A defibrillator was available on the premises and oxygen with adult masks. We were told that staff had used the emergency equipment when dealing with emergencies both within the practice and in the street outside the practice. There was also a first aid kit and accident book available. Emergency medicines were held and were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and a range of other guidelines from various bodies. For example, guidelines for the care of patients with mental health issues. The practice had systems in place to ensure all clinical staff were kept up to date by both formal training and the daily team meetings. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. Records reviewed by the CQC GP advisor showed the practice team developed detailed care plans that encompassed both physical and mental health needs of their patients and that these were reviewed on a regular basis. The practice monitored that care and treatment guidelines were followed through risk assessments and audits.

The practice used innovative approaches to support the care of patients. For example the practice supported alcohol reduction programmes that required the patient to reduce their alcohol consumption without recourse to medicines. An agreement was reached with the patient for a phased reduction in their alcohol consumption which was monitored closely by nursing staff. Staff had been appropriately trained in applying this modern technique. Use of this programme reduced the risks associated with medicines and research showed it was an effective programme.

All patients who registered with the practice received a comprehensive health check. This included assessment of their physical and mental health needs. The GP advisor reviewed a sample of five records showing the outcome of the initial patient assessment. These confirmed that comprehensive assessment had been recorded and care plans arising from the assessment had been prepared with patient involvement. Patients benefitted from the range of services at the practice. For example, patients assessed as requiring support to improve their mental health were able to see the mental health worker at the practice.

Management, monitoring and improving outcomes for people

The practice ensured the needs of patients with long term conditions were met. Disease registers were in place and practice staff led in delivering services for patients with a variety of complex medical conditions. For example a practice nurses took the lead in supporting patients with respiratory diseases and diabetes. Due to the specialist nature of the service the practice performance in meeting Quality Outcomes Framework (QOF) targets a meaningful comparison to the performance of other practices could not be drawn. (QOF 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. Current results were 83% of the total number of points available. This showed the practice performed well when taking account of the patient population they served. Many patients with long term conditions did not stay registered for long enough to complete all the health checks and tests required for their condition. We saw that the practice used the most up to date guidance when completing reviews of patients with long term conditions and completed detailed records of the annual checks and action taken to improve the health of this group of patients.

A wide range of clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patient outcomes. For example, nurses had undertaken audits of long term diseases including diabetes, stroke and hypertension. The findings from audits were discussed at the monthly multidisciplinary team meetings. We were shown 12 clinical audits undertaken in the last two years. Six of these were completed audits where the improvements made were implemented and monitored. An audit of fractures we reviewed showed that the action identified from the first audit had resulted in a 50% reduction in fractures when the second audit took place. The practice participated in applicable local audits, national benchmarking and research. Findings were used by the practice to improve services. For example, recent action taken as a result included reducing the prescribing of antibiotics in line with national best practice.

Good

Are services effective?

(for example, treatment is effective)

Information about patient's outcomes was used to make improvements such as; focusing on reducing alcohol consumption as an audit of deaths showed excess alcohol consumption to be a contributory factor.

Effective staffing

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

- The practice had an induction programme for all newly appointed 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 and information governance awareness. However, administration and reception staff did not receive training in basic life support. Staff had access to and made use of e-learning training modules, in-house training, trust wide training and external training courses. Staff we spoke with gave us examples of training they had accessed including: alcohol abuse awareness and updates on the effects of psychotropic medicines (medicines used in the care of patients with mental health problems).
- Learning from training was shared via the daily team meetings. We also saw that the monthly team meetings included opportunities to learn from visiting speakers. For example an update in safeguarding was scheduled for the meeting on 1 October 2015.

The practice offered learning opportunities to both medical and nursing students attending local universities. Medical students were offered the opportunity to observe for three morning sessions. One of the GPs lectured on registrar training courses on the subject of substance misuse.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services. We saw that the daily team meeting was used to keep all members of the team informed of discharges from hospital, admissions to hospital, referrals and any major changes in the care needs of patients with complex needs.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patient's needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings involving visiting professionals took place on a monthly basis and that care plans were routinely reviewed and updated. The daily team meeting was attended by all members of the practice team. It was used to ensure everybody was kept up to date with changes in patient's needs and their medical conditions. We attended the daily team meeting and saw how the team co-ordinated care for a patient who had been discharged from hospital.

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. Staff we spoke with gave us examples of where they had used the act. They also told us they had access to immediate advice from the specialist mental health worker when they had any concerns relating to patients who may not have the capacity to make decisions about proposed care and treatment. The practice training plan showed us that further training in the application of the Mental Capacity Act 2005 was scheduled for November 2015. One of the GPs at the practice was an approved second opinion GP for application of sections of the Mental Health Act 1983 (amended in 2007).

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, those at risk of developing a long-term condition and those requiring advice on smoking cessation and alcohol intake reduction. Patients were given advice and support when their needs had been identified.

Good

Are services effective?

(for example, treatment is effective)

Nurses at the practice offered and delivered alcohol reduction programmes. Smoking cessation advice was given by trained counsellors in the practice team. Due to the constant turnover of patients it was difficult to audit success rates of this intervention. Advice was offered on pregnancy avoidance and safe sex. Free condoms were available from the clinical staff.

The practice offered a comprehensive screening programme. The practice nurses offered cervical screening. It was recognised that take up of cervical screening among homeless women was less likely than among women in other groups. The practice had very few female patients registered (approximately 15% of the registered patient population) and patients registered then left the service frequently. However, 26 patients had their cervical smear in 2014. We noted that the practice nurses audited their success rates in taking cervical smears.

The practice nurses made significant effort to encourage patients to engage in treatments and tests known to be of benefit for patients who were homeless or vulnerably housed. The difficulties in making contact with patients who were homeless made follow up complex. However, 122 patients received their flu vaccination during the 2014/15 flu vaccination campaign.

Patients received a comprehensive health assessment when they first registered with the practice. Appropriate follow-ups on the outcomes of health assessments and checks were made, where risk factors were identified or involvement of other agencies was regarded as appropriate. Referrals were made to hospitals in a timely manner and patients were offered the support of volunteers to attend hospital appointments. When a referral was made this was discussed by the practice team at their daily team meeting in order to co-ordinate the support required for the patient.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. We observed reception staff keeping patients informed of their appointment progress when they needed to see both the nurses and the GP. This was carried out in a kind and informative manner and put the patient at ease. When a patient was overheard talking to another patient about needing to see the chiropodist a member of staff immediately asked if they wanted to book an appointment then or check their diary first. Staff were highly motivated and inspired to ensure patients received a kind and caring service.

Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

The CQC comment card completed by one patient was positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with a member of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The eight patients we spoke with highlighted that staff responded compassionately when they needed help and provided support when required. Patients also told us that staff and the GPs put them at ease and made them feel safe using the service. Some patients commented that they had found it difficult to access services elsewhere but felt comfortable and motivated to attend the practice.

Because patients had no address and came and left the service frequently there were no results from the national GP patient survey. However, the practice had commissioned an independent survey company to carry out a patient survey. The survey was undertaken in December 2014 and 46 patients took part. The results were consistently positive about the way patients were treated with compassion and respect:

- All of the patients were positive that the GPs were good at listening to them.
- 97% said the GP put them at ease.
- 100% said the practice nurses gave them enough time.
- 98% said the practice nurses listened carefully to what they said.
- 91% said the care they received was either good or excellent.

In addition to the survey results comments from patients who took part in the friends and family test were also consistently positive. Most patients commented about how kind the staff were and how staff both put them at ease about their treatment and went out of their way to provide care and support.

We were given examples of staff visiting patients in very difficult surroundings. For example, patients who were living outdoors and who would not attend the practice. Staff visited a patient in these circumstances because they were concerned about their health and wellbeing. Following assessment the patient accepted the treatment offered. Staff went out of their way to engage patients in receiving care and support. For example, by regularly visiting a patient who had been 'sleeping rough' they gradually reduced the patient's reluctance to receive care and support. After some time the patient was able to accept a place in one of the local hostels.

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.

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

Outstanding ☆

Are services caring?

- 100% said the last GP they saw explained tests and treatments either to some extent or completely.
- 97% said the last GP they saw was good at involving them in decisions about their care and treatment either to some extent or completely.
- 97% also said the practice nurses were good at involving them in decisions about their care and treatment either to some extent or completely.

Again the comments patients made about involvement in decisions about their care were positive.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

When patients identified a wish to take up pursuits or engage in employment the practice used their contacts with other organisations to meet the patient's needs. There were examples of patients obtaining grants from the Oxford Homeless Medical fund to access educational courses that could assist in obtaining employment. For example a patient had taken a recognised computer course.

Patient/carer support to cope emotionally with care and treatment

There was a range of information available both in the patient waiting room and via the practice team which told patients how to access a number of support groups and organisations. Records of consultations reviewed by the CQC GP advisor showed that patients were given advice on how to access support groups and we found that there was close working with these groups. For example with local charities and with housing associations. Patients were supported to take up opportunities to access services they might not have otherwise considered. For example joining cookery clubs or allotment societies. There were also examples of patients moving into their own homes and moving on to register with GP practices close to their new home.

Comments from patients who took part in the practice survey were positive about receiving emotional support from practice staff and we saw that patients could bring a friend or carer to their appointments to support them.

If the patient had advised the practice they had relatives or close friends these people were contacted upon the death of a patient. A bereavement counselling service was available at the hostel next door to the practice and friends or relatives who had suffered bereavement were encouraged to access this service if they wished to.

The practice worked with a wide range of organisations in delivery of care and treatment. This included meeting patients social care needs in addition to their health needs. For example, benefits advice was available at the practice. The practice had also won an award in 2014 for their work in supporting patients who needed to attend hospital. Research had shown that homeless patients found it difficult to attend hospital. The practice had worked with volunteers to establish a PATH (Patient Access to Hospital) service which provided a volunteer to take a patient to hospital for their appointment. The patient could request the volunteer to assist them during their consultation as an advocate if they so wished. The practice demonstrated that this service had reduced the number of patients who failed to attend for their appointment. Patients were therefore more likely to receive the care and treatment their condition required.

Outstanding ☆

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, voluntary groups and a variety of agencies to plan services and to improve outcomes for homeless people. For example, staff visited patients at four local hostels and a social practitioner was available at the practice to assist patients with their social needs. Services had been expanded in since the practice first opened to include: podiatry, dentistry and specialist mental health practitioners.

The practice formed an integral part of the Oxford Homeless Pathways service. This meant that access to a wider range of services could be co-ordinated by the team at the practice. For example access to the 'Step up' project which offered:

- A variety of internal training courses including numeracy and literacy, preparation for maintaining future tenancies, and other vocational subjects. Help for clients to take advantage of external courses.
- Help finding voluntary and paid work in the community, with support to write CVs, prepare for interviews, and to access external training courses that help clients get back into employment.
- A wide range of sports and leisure activities such as canoeing, football and rounders. Museum-visiting group and a scrabble group.
- An internal grant-awarding scheme – the 'Personalisation Fund'. Distributing small grants to individuals to help them access life-changing education or employment opportunities or physical activities.

The close involvement with other agencies such as the probation service and Oxford Homeless Pathways meant that homeless people were made aware of the service and were encouraged to register at the practice to ensure their health needs were met.

Services were planned and delivered to take into account the complex range of needs of the homeless. For example;

- The practice offered 20 minute appointments as routine. This recognised the needs of the patient group who frequently wished to discuss a range of health and social needs.
- Longer appointments were made available for patients with long term conditions.
- Staff visited patients living in local hostels or sleeping rough who could not, or declined to, attend the practice.
- The practice offered a walk in and be seen service every weekday morning. This recognised the difficulty many homeless patients experienced in making contact with a practice to arrange an appointment in advance. The results from the patient survey showed that 73% of patients who responded used these walk in appointments. Comments supporting the survey and patients we spoke with highlighted the value of these appointments.
- Referrals to hospital were made in a timely manner and patients were supported to attend their appointments.
- There were disabled facilities and translation services available.
- Patients were able to access a range of services at the practice. This was particularly helpful for the homeless who experienced difficulties in travelling to other services.
- Advice on housing and benefits was available at the practice
- The close links with local hostels meant that people who took up a hostel place could be directed to the practice immediately health needs were identified by hostel staff.

The practice also supported patients with:

- The provision of advocacy services.
- A needle exchange service for intravenous drug users.

There was an active Patient Participation Group (PPG) (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care), which met regularly and was led by one of the patients at the practice. We looked at some of the minutes from the meetings of the group and noted that they had involved members of the local church and from Healthwatch. There were a number of sub groups at the hostels in Oxford to ensure homeless people were able to contribute their views about how the service ran. A notice board in the waiting room contained information about the group and updated patients on the issues that were being considered. There was also a suggestion box for patients to post their comments. We saw that the practice had upholstered the chairs in the waiting room in response to a

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

request from the PPG. There were plans in place to install CCTV to the outside of the practice to improve patients safety in response to a PPG request. We noted that the PPG had won a highly recommended award from the National Association of Patient Participation for their work in 2014.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8am to 12.30pm every morning and 2pm to 5pm daily. The morning clinics included a walk in service between 9am and 12.30pm when patients could attend without an appointment. This service was very popular with the patients. A GP was on duty from 5pm to 6.30pm to respond to urgent requests for advice, care and treatment and to attend the local hostels if required. Appointments were not made after 5pm due to security concerns for the safety of patients and staff. The afternoon appointments could be booked up to four weeks in advance. The system enabled patients to access services at times to suit them and they were able to see a GP or nurse of their choice.

Results from the independent patient survey commissioned by the practice showed that patients were positive about the access they had to the service. This was also reflected by the eight patients we spoke with and the one comment card we received. The results of the practice survey could not be compared with the national patient survey, because some different questions were asked. However, when similar questions were asked the results compared very favourably with local and national averages. For example:

- 91% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 89% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.

Patients who had completed the friends and family test survey and those we spoke with were complimentary about the walk in service offered by the practice every morning. They were also very positive about the short waiting times they experienced.

Patients who moved on to register with other GP practices were able to maintain their contact with the practice during their transition. This was particularly helpful for patients who had complex health and social care packages which had been agreed with the practice team.

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. Time was scheduled in practice meetings to review complaints and there was a system to report complaints to the Trust management. The practice had not received a complaint in the last three years.

Patients could access information about how to complain via the information board in the waiting room or by asking at reception. Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint but they told us they had not had to make one.

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. Staff were clear that all members of the team were involved in improving the health and wellbeing of the vulnerable group of patients the practice served. The practice took part in research linked to their participation in the inclusion for health agenda. It had been accepted to undertake a wider range of research from 2016.

Governance arrangements

Governance and performance management arrangements are proactively reviewed and

reflect best practice. The governance framework, was linked to the NHS Trust management team, which supported the delivery of 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
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements to a patients care and treatment.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The GPs and senior managers at the practice prioritised high quality and compassionate care that reflected the physical health, mental health and social needs of the patients. Management of the practice was undertaken within the overall management framework of the NHS Trust and some decisions in regard to allocation of resources and application of policies had to be referred to senior Trust management. For example, local managers operated within trust personnel and recruitment processes and when improvements or refurbishment of the practice was required this was referred to senior Trust managers for allocation of resources. When training in basic life support for administration staff was identified as needed the local managers could not organise this without authorisation from senior trust management.

The GPs were visible in the practice and staff told us that they were approachable and always took the time to listen to members of staff. The managers and GPs encouraged a culture of openness and honesty.

Daily team meetings were held to review the care and support patients required. The team discussed a wide range of topics each day including patients admitted to hospital, patients referred to hospital, links with voluntary organisations providing support to patients and how patients were progressing with their care and treatment. We attended the daily team meeting and noted the open culture within the practice. Staff had opportunity to raise any issues at team meetings. They were confident in doing so and felt supported if they did. We also noted that the Lead GP, Senior Nurse and Practice Manager held a service review and planning meeting once a year. The outcome of the review was shared with staff via the regular team meetings. 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 and all were encouraged to identify opportunities to improve the service delivered by the practice.

A systematic approach was taken to working with other organisations to improve care outcomes, and tackle health inequalities. The practice team worked collaboratively with a wide range of voluntary organisations for example, liaising with these organisations to enable patients to take part in activities such as tending allotments, cookery courses and education courses. It was a member of the College Faculty of Inclusion Health and adopted the best practice standards for homeless health that the faculty endorsed.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys. There was an active PPG which met on a regular basis and held sub groups at the local hostels. Minutes of PPG meetings

Are services well-led?

Good

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

showed us that the practice responded to issues raised at PPG meetings. We also saw that the practice had made improvements to the environment in response to PPG comments. The practice had commissioned its own patient survey. The results were very positive and there was no action to take arising from the results.

There are high levels of staff satisfaction. Staff were proud of the organisation as a place to work and speak highly of the culture. There are consistently high levels of constructive staff engagement. Staff at all levels are actively encouraged to raise concerns. The practice gathered feedback from staff through the daily team meetings, appraisals and day to day discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw that managers had followed up the request from staff for basic life support training and had raised their concerns with the management of the Trust. Staff told us they felt involved and engaged to improve how the practice was run. Our attendance at the daily team meeting and minutes of the monthly multidisciplinary team meetings showed us that all staff took an active role in supporting high quality delivery of patient care and to the development of the practice.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice also developed new ways of improving services and access to services for the registered patients. For example, the allocation of a volunteer to attend hospital appointments with patients reduced the risk of the patient failing to attend their appointment. Up to date treatment programmes were followed including alcohol reduction without medicines. The practice sought to expand services when opportunities arose. For example, adding mental health practitioners to the team and a social care practitioner in the last 15 years. The practice was forward thinking and took part in local pilot schemes to improve patient care For example, the crack cocaine project and visiting TB bus.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **12.**—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; • Non clinical staff had not been trained in basic life support (BLS). • A risk assessment to determine the need for non-clinical staff to be trained in BLS had not been undertaken.