Dr Kenyon and 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.

Contents

Summary of findings

Overall summary

Dr Kenyon and partners (locally known as 19 Beaumont Street) is a General Medical Practice situated in central Oxford. Over 13,000 patients are registered with the practice. The practice provides a range of services for patients which includes clinics for the management of long term conditions, family planning, travel clinic and child health clinics. Patients are signposted to and supported by other health care professionals who visit the practice and by local voluntary groups.

We spoke with 18 patients during our inspection. Patients we spoke with were complimentary about the care and support they received from the GPs and staff at the practice. However, a few of the patients we spoke with told us that they found the practice premises difficult to use because of the layout. We looked at the results of the last practice survey. This showed us that patients were consistently pleased with the service they received.

The practice is a member of the Oxfordshire Clinical Commissioning Group (CCG) and is in the Oxford City locality. A GP and the practice manager attend CCG meetings. One of the GPs is a member of a group assessing the opportunity to commission health and social care services specific to the population of the locality. The practice is also accredited to carry out training of GP trainees.

Procedures to safeguard vulnerable patients are in place. However, systems to monitor cleanliness and reduce the risk of cross infection require improvement. The practice is effective because current guidelines in care and treatment are followed. Audits to review quality of care are carried out. The practice demonstrates a commitment to caring for their patients. The interactions we observed during our inspection were polite and respectful. Services are responsive. A range of appointment options are available and referrals to specialist services are made promptly. The practice is well led. GPs have clear areas of responsibility and patient data is used and stored appropriately.

Clinical data showed us the practice performed well in delivering care and treatment for patients with long term conditions. The needs of working age patients are recognised. A range of appointment times are available and telephone consultations could be offered. Mothers, babies and young children receive services including childhood immunisation clinics and mother and baby health checks. We spoke with some elderly patients they told us they received care and support from the GPs that met their needs. The practice hosted a Citizens Advice Bureau (CAB) benefits advisor to assist patients on low incomes with benefits advice. The GPs referred patients for counselling when appropriate.

We found that the practice was not meeting one of the regulations to reduce the risk of cross infection by operating systems in regard to cleanliness and infection control. We have asked the practice to send us a report, setting out the action they will take to meet these safety standards. We will check to make sure that action is taken.

Services are provided from:

19 Beaumont Street, Oxford, Oxfordshire, OX1 2NA

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 provided services that were safe. However, improvements were required in identifying, assessing and managing risk associated with control of infection. The practice had comprehensive safeguarding policies and procedures in place to protect vulnerable patients. A safeguarding lead had been appointed who had undertaken appropriate safeguarding training. Significant events were discussed in detail with the practice team and we saw that action to reduce the risk of recurrence was recorded and taken. We found the practice had robust medicines management systems in place. Equipment used in the delivery of care was appropriately serviced and maintained. Building plant and equipment was subject to relevant safety checks and certification. There were policies and procedures in place covering management of risk. For example the management of incidents and accidents procedure. Staff demonstrated knowledge of the safety procedures. However, the main practice health and safety policy had not been reviewed in the last year and the building risk assessment had not been updated since 2010. The risks posed to patients from delivering services in a building that was not designed for the purpose of healthcare were not being identified, assessed and managed. The practice had a service continuity plan in place to deal with emergencies that could interrupt the smooth running of the practice. The practice was not following all current guidance and codes of practice to reduce the risk of cross infection. We found two treatment rooms, one of which was used for minor surgery, where the standard of cleanliness posed a risk of cross infection. The procedure for monitoring the standard of cleanliness was not being operated in a way that reduced the risks associated with poor cleanliness. A control of infection audit had been completed in October 2013. However, some of the actions identified to further reduce the risk of cross infection had not been timetabled.

Are services effective?

The practice was effective. There were robust arrangements in place to obtain patient consent. These included supporting patients who found it difficult to give informed consent. Data we reviewed showed us the practice had achieved 99% of the care targets contained in the national quality framework standards (QOF). The practice had an up to date recruitment policy in place that met the requirements of the recruitment regulations. The practice had a clinical audit plan and we saw that audits took place. Some prescribing audits had been repeated to ascertain whether improvements in prescribing

practice identified had taken place. The GPs had a system of reviewing patient referrals to hospital to ensure referrals were appropriate and followed recognised patient care protocols. Information was exchanged in an efficient manner between the practice and hospital departments. A range of health promotion material and services were available to patients. For example we saw that practice nurses were trained to offer smoking cessation advice and support.

Are services caring?

The practice was caring. The GPs and staff we spoke with demonstrated a caring approach. Patients were extremely positive about the care they received. The patient's view that practice staff were caring was reflected in the local patient survey, on comment cards CQC reviewed and by patients we spoke with on the day of inspection. We saw that staff were caring and respectful in their interactions with patients. Patients we spoke with told us how they were involved in making decisions about their care. The practice respected confidentiality of patient information by ensuring data was held securely. Patient information about how the practice stored records and personal information was displayed at the reception and on the practice website. This included information on how patients could access their own records.

Are services responsive to people's needs?

The practice was responsive to patient needs. The practice ran 12 minute appointments to give more time for consultations (the national standard length of appointments is 10 minutes). There was a range of appointment options available to patients and evening and weekend clinics were held. Provision to book appointments online was available. Patients we spoke with told us they were given clear information on how to obtain results of medical tests. There was a clear complaints policy and patients we spoke with told us they would feel able to offer comments about the service they received. Advice about how to make a complaint was available on the practice website and from the reception desk. The practice understood the different needs of the population it served and acted on these to ensure the service they provided offered appropriate support. The practice participated in discussions with local commissioners about how to improve services for patients in the locality. One of the GPs was working on a project looking at local commissioning of health services for the City of Oxford. An open registration policy was in place and the practice supported the care of patients living in a bail hostel and a probation hostel. The practice made provision for patients with a disability to access services.

Summary of findings

Are services well-led?

The practice was well led. There was a strong ethos throughout the practice team to deliver accessible patient care of the highest quality. Staff were fully aware of their roles and what decisions they could make. Practice management and GPs demonstrated strong leadership and a commitment to their patients and staff. A patient participation group was in place and they supported the practice in conducting an annual patient survey. Development and improvement for the GPs and their staff was supported by a performance review process and by a visible commitment to training. Governance structures were in place and the practice had completed a nationally recognised process to ensure safety and proper handling of confidential data. We saw that a GP had been appointed to hold responsibility for ensuring patient data was used appropriately and held securely.

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 had a lower than average number of older patients registered compared to the rest of Oxfordshire. The Quality and Outcomes Framework (QOF) data we reviewed showed good performance in managing long term medical conditions associated with patients over the age of 75. The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients.

Patients over the age of 75 were allocated a named GP. The patient's care and treatment needs would be known and followed up by one GP.

We saw that arrangements were in place to provide flu vaccinations and other vaccinations appropriate to this group of patients. If a patient was unable to attend a flu vaccination clinic they could attend at a time that was convenient to them. If the patient was unable to attend the surgery arrangements were supported to administer their vaccinations in their own home.

Home visits were arranged for the frail elderly to avoid them having to make difficult journeys to the practice. The practice did not support patients living in any nursing or care homes but GPs told us they would be happy to do so if requested.

There was a system in place to communicate information relating to end of life care to the Out of Hours service.

People with long-term conditions

The practice supported patients with long term conditions. Disease registers were maintained that identified these patients. There were recall systems in place to ensure patients received monitoring and support. One of the practice nurses had identified patients with more than one long term condition and was working on a system to carry out a co-ordinated follow up for them. This would help the patient avoid multiple appointments with nurses and GPs.

We were told that when a GP diagnosed a long term condition they made an entry in the patient record which would establish the need for a regular review. We found that when a patient joined the practice with a pre-existing long term condition this was entered in their notes and a recall for annual review was set up.

The GPs followed national guidance for reviewing all aspects of a patient's long term condition because recommended care templates were in use. We saw that the practice achieved over 99%

of the clinical targets for care of patients in this group. If a patient did not attend for their review there was a system in place to remind them of the importance of their health check. We saw that this group of patients were offered an annual flu vaccination.

The practice offered clinics for patients with long term conditions run by practice nurses. We saw that the nurses who managed these clinics had received additional training specific to the care needs of this group. For example training to support patients with diabetes. However, if attending the clinic was not convenient the patient could book to see either the appropriately qualified nurse or their GP for their review at a time that suited them.

GPs offered their e-mail address to patients with long term conditions. Patients who had a question about their treatment or care could e-mail their GP with their question or concern if they felt they did not need to be seen for an appointment.

Mothers, babies, children and young people

The practice delivered services appropriate to the needs of mother, babies, children and young people. Systems were in place to invite parents or guardians to bring babies and young children for childhood immunisations. We saw that immunisation take up was over 90% for all immunisations. Nurses who were not fully trained and experienced in administering childhood vaccinations did not do so until their competency was checked. There were records showing that nurses attended relevant training in administration of childhood vaccinations.

Mother and baby health checks were carried out and there was a system to alert Health Visitors if the mother and baby did not attend.

There was close liaison with the college nurses at the university. Sexual health clinics and counselling services were available for the younger university students. Practice nurses told us they gave family planning advice to university students on a regular basis. Students were able to book appointments at times that they found suitable. Close liaison with the university college nurses and student support services was in place.

Expectant mothers were able to see their midwife at the practice and there were systems in place to support liaison between GPs and midwives to ensure care for expectant mothers was co-ordinated.

The working-age population and those recently retired

The practice offered a range of services to patients of working age and those recently retired. For example, there was a visiting physiotherapy service. Counselling and sexual health clinics were available and family planning advice was offered by practice nurses.

Summary of findings

Access to a variety of appointment types was available. Evening surgeries ran on two evenings a week and a Saturday morning surgery was held. If patients found it difficult to attend the surgery they could request a telephone consultation. Appointments could be booked online. The practice had a higher than average number of patients of working age. This was due to supporting 12 colleges at Oxford University. E-mail and telephone consultation services were available which offered alternatives to patients who found it difficult to find the time to attend the practice.

Where electronic communication was available to specialist services this was used to avoid the need for this group of patients to attend further appointments at hospital. For example photographs of suspected skin complaints could be sent to the dermatologists for a diagnosis.

People in vulnerable circumstances who may have poor access to primary care

The practice recognised the needs of and offered services to patients in vulnerable circumstances. There were contracts in place to deliver medical services to a bail and probation hostel.

A Citizens Advice Bureau advisor attended the practice to offer benefits advice to patients on low incomes.

There were very few patients with a learning disability registered with the practice. One GP took responsibility for caring for these patients and we saw that they received an annual health check-up.

People experiencing poor mental health

The practice offered a range of services to patients experiencing mental health problems. Patients were referred to counselling services when appropriate. A range of leaflets detailing local self help and support groups was available. The practice took an active role in supporting patients with drug and alcohol addiction. Shared care agreements were in place with the local addiction team and a nurse specialist in addiction treatment visited the practice to support patients. Some of the GPs had specialist expertise in working with patients with mental health problems.

Summary of findings

What people who use the service say

We spoke with 18 patients on the day of our inspection. We reviewed five comment cards that patients had completed in the two weeks prior to inspection. We also looked at the results of a national patient survey conducted in 2013 and the practice patient survey conducted in early 2014. The comments patients had posted on the NHS choices website were reviewed before the inspection took place.

The patients we spoke with on the day of the inspection were very positive and complimentary of the care, treatment and support they received from GPs and practice nurses. They told us they could access a range of appointments and that the staff team supporting the GPs and nurses were polite, helpful and respectful. A number of the patients we spoke with told us that they found the GPs explained care and treatment very well and that they felt fully involved in making decisions about their care. The results of the national patient survey showed us that 88% of 216 patients who responded also said the GPs were good at explaining tests and treatments.

Areas for improvement

Action the service MUST take to improve

- Improve standards of cleanliness and hygiene in treatment rooms and general areas of the practice. With appropriate monitoring.
- Improve the decoration and refurbishment of treatment rooms to reduce the risk of cross infection and timetable actions identified in the control of infection audit.
- Health and Safety procedures and appropriate risk assessments must be up to date and current to ensure risks to patients and staff arising from the premises were identified and action taken to reduce risk.

Action the service SHOULD take to improve

- Consistently operate the practice annual staff appraisal process.
- Record and disseminate the discussions from all staff meetings. Particularly when issues of quality, learning and training have been discussed.
- Undertake a risk assessment to review reception and administration staff training in basic life support.

Outstanding practice

The practice offered online booking of appointments and Saturday morning appointments with GPs.

Dr Kenyon and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor. The team included a practice manager advisor, a second CQC inspector and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to Dr Kenyon and Partners

Dr Kenyon and partners (locally known as 19 Beaumont Street) is located in the centre of Oxford. It is situated in two large Georgian terraced buildings. Patients are mainly from the central Oxford area. Over 13,000 patients are registered with the practice. More than 6,000 patients are university students because the practice has links with 12 colleges at Oxford university. Therefore, the practice offered services to a larger number of younger patients than many other practices in Oxfordshire. The practice performs well against nationally recognised quality standards. Clinical outcomes data shows over 99% of targets were met. A wide range of primary medical services are provided including clinics for patients with long term conditions and for child health. The practice has links with other clinical services and supports patients in accessing these services. For example college counselling services and physiotherapy clinics.

Care and treatment is delivered by eight GPs, four practice nurses and two health care assistants. The clinical team is supported by the practice manager, the patient services manager and a team of administration and reception staff. The practice is accredited to provide training for GP trainees. The practice is a member of Oxfordshire clinical commissioning group (CCG) and the Oxford City Locality sub group of the CCG. One of the GPs and the practice manager are members of the locality board of the CCG. Another GP is working with the locality group on a project to develop stronger links between practices to commission services specific to the Oxford City area.

Feedback from patients is generally positive with 85% of 114 patients who took part in a national survey rating their overall experience of the services as good or very good and 81% would recommend the practice to others. The feedback we received from the 18 patients we spoke with on the day of inspection was positive.

There were arrangements in place for patients to access emergency care from an Out of Hours provider. However, some of the patients we spoke with told us that they were not aware of the procedure to follow to access out of hours services.

The practice is located at:

19 Beaumont Street, Oxford, Oxfordshire,OX1 2NA

Why we carried out this inspection

We inspected this GP practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting the practice we received information from local organisations including NHS England, Healthwatch

Detailed findings

and the Oxfordshire Clinical Commissioning Group (CCG). We carried out an announced visit on 10 July 2014. During our visit we spoke with a range of staff, including GPs, practice nurses, practice manager and administration staff. We observed how patients were cared for and how staff interacted with patients. We also spoke with 18 patients who used the service. We reviewed management records.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Are services safe?

Our findings

Safe Track Record

The practice had systems in place to deal with national and local safety alerts. When information about a medicine that needed to be withdrawn or dose changed was received it was passed directly to the GPs for action. The GPs took action to ensure medicines were changed appropriately and informed the patient's affected. The need for the change was discussed with each patient. Any safety alerts relating to medical equipment were passed to the nurses to take action. Once the action had been taken the nurses reported back to the practice manager. The practice manager kept a record of the actions taken with regard to safety alerts. Staff we spoke with were aware of their responsibility to report any safety concerns to the practice manager.

Learning and improvement from safety incidents

We saw that the practice carried out regular reviews of significant events. The records we saw showed us that full investigation of any significant event was carried out. Learning from the incident was shared with the practice team through staff meetings. We saw that measures identified to avoid recurrence were documented in the minutes of the meetings. Staff confirmed that the learning from incidents relevant to their roles and responsibilities was shared with them. There was a significant event reporting form available which staff were aware of.

Reliable safety systems and processes including safeguarding

Children and vulnerable adults were protected from the risk of abuse because the practice had taken reasonable steps to identify and prevent abuse from happening. The GPs and practice nurses were trained appropriately in safeguarding and there was evidence that the practice took part in local clinical commissioning group (CCG) audit of safeguarding referrals. We saw minutes of practice meetings that showed us safeguarding issues were discussed regularly. The practice had a safeguarding policy and this included the contact details of the local authority safeguarding team. We spoke with four members of the practice administrative and clerical staff. They told us they had received training in safeguarding and were able to demonstrate an understanding of the various types of abuse they could encounter during the course of their duties. There was evidence that online safeguarding training courses had been taken by administrative and clerical staff and that they took part in seminars organised by the GPs on this topic.

Monitoring Safety & Responding to Risk

Systems were in place to act upon safety alerts from national bodies. For example, national directives relating to withdrawal of medicines or change of dosage were immediately sent to all GPs. Patients taking the medicines in question were alerted and called in to discuss the changes in their medication that were required. If a warning relating to clinical equipment was received this was passed to the practice nursing team to take appropriate action. We saw that fire safety checks and fire drills were carried out.

However, the practice health and safety policy had not been reviewed for over a year and the premises risk assessment was dated 2010. Risks associated with the age of the premises had not been reviewed in the last four years. Patients we spoke with commented on the uneven floors and on the day of the inspection we found a fire door that when closed became stuck. Patients and staff could have been trapped in the rooms behind this door. We alerted the practice manager and they arranged for a maintenance person to visit the next day to fix the door. There were no warning signs advising patients of the trip hazards associated with the uneven floor surfaces.

Medicines Management

We saw that medicines were stored securely and that appropriate monitoring and recording systems were in place. A small stock of controlled drugs were held in a locked cupboard of approved design and that access to the keys for this cupboard was restricted to clinical staff. We looked at the controlled drug registers and saw that accurate recording had taken place. Drugs that were either out of date or returned by patients awaiting destruction were appropriately recorded and securely held. Prescription pads were stored safely. When boxes of prescriptions were delivered they were signed for and taken to secure storage immediately. We saw that when GPs and nurses left their rooms the doors were locked preventing access to printers containing individual prescriptions. There was a system in place for reviewing repeat prescriptions and we saw that patients who failed to attend for their prescription review were followed up and

Are services safe?

reminded to attend their review. The small stock of medicines held at the practice was checked regularly by one of the nurses and we saw that expiry dates were recorded to ensure medicines did not go out of date.

Vaccines were appropriately stored in dedicated fridges. The temperatures of these fridges were checked and recorded on a daily basis. We reviewed the fridge temperature records and saw that there had been no anomalies in temperatures recorded. Vaccines were kept safely and systems were in place to ensure they were safe to use.

Cleanliness & Infection Control

We saw that the practice had a cleaning schedule and that a member of staff was responsible for meeting with the cleaning contractors to monitor the quality of cleaning achieved. However we found some general areas of the practice were dirty. For example stairways to GPs rooms and treatment rooms showed accumulation of dirt and grime around skirting boards and below the handrails. The GP rooms we looked at were clean and desks were kept tidy. We saw that two treatment rooms, one of which was used for minor surgical procedures, were not adequately cleaned and maintained. The flooring in these rooms was not sealed to the skirting boards. Dirt and debris had built up between the flooring and the skirting board. Skirting boards and the areas behind radiators had not been cleaned appropriately. The wall next to the couch in the treatment room used for minor surgical procedures had stains and dirty marks on it. The poor cleaning standards achieved in these rooms increased the risk of cross infection.

There was a control of infection policy and a member of the nursing team was the lead for control of infection. We saw that clinical rooms had supplies of hand gel and paper towels and hand washing guidance was displayed. A control of infection audit had been carried out in November 2013. Some actions had been identified but timescales to complete the action had not been -agreed or recorded. The practice policy made no reference to the code of practice for GP surgeries and there was no annual statement of control of infection available.

We looked at the contract for disposal of clinical waste and at the documentation confirming that clinical waste had been collected by the approved contractor at regular intervals. The bins holding clinical waste bags were kept securely and were locked. We looked at five sharps bins. Only three were labelled and dated in accordance with hazardous waste guidelines.

Staffing & Recruitment

We found recruitment and selection processes were in place. The practice manager told us, and staff we spoke with confirmed, that staff that required a criminal record check through the Disclosure and Barring Service (DBS) (previously Criminal Records Bureau (CRB) had completed this check. We saw records confirming the checks had been undertaken. We spoke with four members of the administration staff and with three nurses. All of them told us they had been asked to provide references when they were appointed, had submitted a CV and had provided proof of identity. We looked at staff personnel files and found that the appropriate range of checks had been completed.

Dealing with Emergencies

Appropriate equipment, drugs and oxygen was available for use in a medical emergency. The emergency equipment was checked regularly. We saw evidence of these checks and that when a check identified a need for repair or replacement this had been carried out. All of the GPs and nurses at the practice received annual training in basic life support. The practice had made a decision not to train administration and reception staff and ensured a GP or nurse was on the premises at all times when patients were present. This could delay immediate response to a medical emergency whilst a trained GP or nurse was located within the four storey building. The administration and reception staff we spoke with were all aware of where the emergency equipment was kept and told us they could support a GP or nurse by getting the emergency equipment and calling for assistance or an ambulance. The practice had not carried out a risk assessment to evaluate their decision not to train administration and reception staff in basic life support.

There was a comprehensive plan in place to deal with situations that might affect delivery of patient care. This service continuity plan included what to do if the building became unusable for any reason. Staff we spoke with were aware of this plan and their role in dealing with situations that might arise that interrupted services to patients.

Equipment

We looked at records which confirmed essential equipment had been serviced and maintained in accordance with

manufacturers' instructions. The records also showed us that where equipment required regular calibration that this had been carried out. We also reviewed records of servicing and certification to essential building and plant. For example we saw the fire alarm system was regularly maintained and certified in working order.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Care and treatment was delivered in line with recognised best practice standards and guidelines. There was evidence the practice kept up to date with new guidance and legislation. GPs and nurses followed the relevant National Institute for Health and Care Excellence (NICE) guidelines in the management of patients with long term medical conditions. The protocols to follow were embedded in the practice database.

GPs and nurses we spoke with were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately.

The practice took part in local prescribing audits. The practice was able to compare their prescribing with other GP practices in their usage of specific medicines.

Management, monitoring and improving outcomes for people

The practice participated in benchmarking programmes nationally and locally including the Quality and Outcomes Framework (QOF). The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice achieved high results in 2012/2013 against the national quality framework standards (QOF). These included the clinical, organisational and patient experience domains. The GPs we spoke with were aware of their performance against the national quality standards and were committed to maintain their performance of over 99%. We saw that the practice had conducted an audit of referrals to hospital dermatology services. We noted that there had been an increase use of e-mail consultation with specialist dermatologists. This saved some patients from having to attend the dermatology clinics at the hospital.

The practice demonstrated an understanding of the health issues affecting the population of Oxfordshire. For example, an audit of skin cancer diagnosis had been carried out because data showed the incidence of a certain type of skin cancer in Oxfordshire was higher than the national average. The Practice had a system in place for completing clinical audit cycles. We saw that a range of clinical reviews and audits had been undertaken. These included audits of prescribing specific types of medicines. Two of the prescribing audits had been repeated to evaluate whether action from the first audit had been taken.

The practice was aware of their patient demographics and how this affected both practice workload and levels of referral. For example, more family planning advice was given due to the high number of university students registered.

Doctors in the surgery undertake minor surgical procedures in line with their registration and NICE guidance.

Effective Staffing, equipment and facilities

We reviewed personnel files. These contained the appropriate checks and documentation. We saw that the practice had decided to carry out police checks with the disclosure and barring service (DBS) (previously the criminal records bureau (CRB)) for all staff and that these had been carried out. Staff we spoke with confirmed they had undergone these checks.

We found induction for new staff was not being operated. We were told that shadowing of experienced staff took place and that new staff were made aware of important policies and procedures. However, an induction checklist was not used to ensure every aspect of induction had been completed. A member of staff we spoke with who had joined the practice within the last year told us that they had received a formal review of their performance and competency at the completion of their probationary period.

Training and professional development was in place. There was a record of training undertaken by staff and a programme for future training required. The staff we spoke with told us that when they identified training needs training was received. The practice was active in maintaining training for GPs and practice nurses. We saw that seminars relating to specific clinical topics were held at the practice and GPs and staff from neighbouring practices were invited to attend. Three of the five staff we spoke with received an annual appraisal. However, we noted that two members of staff had not received an appraisal every year.

There were systems in place to disseminate learning. There was a structure of team meetings. The frequency of

Are services effective?

(for example, treatment is effective)

meetings varied depending upon the staff group. For example, nurse team meetings were held every month and reception team meetings every quarter. We saw that the reception team had met in March 2014 but, minutes of the meeting had not been retained. All groups of staff took part in the quarterly review of significant events and therefore, accessed the learning from reviewing significant events directly.

The senior nurse was responsible for ensuring nursing staff maintained their professional registrations. The GPs we spoke with described how they and their colleagues undertook revalidation and professional appraisal.

Working with other services

The practice worked with the district nursing team and midwifes. GPs told us there was a clinical meeting every month and the community team was invited. This included the district nurses and nurses from the local hospice. These meetings were used to share information, support patients in receipt of palliative care and to keep hospital admissions as low as possible. The GPs and nurses we spoke with told us these meetings had worked well. The practice promoted a multi-disciplinary approach which had benefited patients.

There was evidence of working with other healthcare professionals and voluntary bodies. Clinics were held at the practice by a physiotherapist, a specialist drug addiction nurse and by counsellors. A few of the patients we spoke with told us they had accessed the physiotherapy service and that it had been efficient.

The practice had systems in place to capture any information of patients who had visited the local hospital. Patients we spoke with who had attended hospital told us when they came back to see their GP that information from hospital clinics was followed up. There was a special notes system in use to alert the out of hours service to any urgent matters relating to patients receiving end of life care.

The patients we spoke with understood the procedures for obtaining results from medical tests they had undergone. Those patients who received regular medication were also clear on the process to request and obtain their medicines.

Health Promotion & Prevention

The GPs we spoke with told us of a range of health promotion services they were able to access for their patients. These included smoking cessation which was available in the practice. Some patients told us they had used this service. Other services included weight management clinics commissioned by the CCG.

Health information was made available during consultation. GPs and nurses used materials available from online services to support the advice they gave patients. A range of health promotion material was available in both the main waiting area and in consultation and treatment rooms.

The practice website also contained health promotion advice and links to other relevant websites where health promotion information was available.

We saw that the practice was meeting the national target for cervical cytology screening. Flu vaccinations were promoted for those patients who were eligible.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The patients we spoke with during our inspection all told us they found the GPs and nurses to be caring. Many of the patients we spoke with also told us the reception staff were kind and helpful. We saw staff interaction with patients was carried out with respect and kindness. For example a member of reception staff left the reception desk to assist a patient who felt unable to check in. Some of the patients we spoke with told us how staff had assisted them by ensuring they were seen by GPs and nurses on the ground floor. We saw that consultations were scheduled at 12 minute intervals to give patients time to discuss their health issues. If a patient requested a double appointment this was made available.

All consultations and treatment were carried out in private rooms. The GPs consultation rooms were suitably equipped and laid out to protect patient's privacy and dignity. We saw one consultation room was immediately beside a waiting area. This room was fitted with double doors so that consultations could not be overheard by patients waiting. Examination couches in GPs rooms could also be curtained off. Consultations were carried out in a way which protected dignity and privacy. Long queues were avoided at the reception desk, which reduced conversations being overheard.

Many calls from patients booking appointments were taken in a back office to avoid the call being overheard by patients attending the reception desk. When a call could not be taken in the office we observed that reception staff did not use names or make reference to patient conditions to maintain confidentiality when other patients were present.

Involvement in decisions and consent

Patients told us staff took time to listen to them and respect their wishes. Patients said they were involved in the decisions about their treatment and care. We saw that written consent was obtained from patients undergoing a minor surgical procedure. The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. Patients we spoke with confirmed that they were asked if they wished to undergo any form of treatment. There was information available on specific treatments that patients could take away to assist them in understanding their treatment and condition.

We observed that when a patient requested to be seen on the day they called for an appointment their request was met. The reception and administrative staff were not required to obtain clinical information from the patient if the patient declined to offer a reason for their on the day appointment. Patients were also able to request a double appointment if they felt they needed longer with their GP than the standard appointment duration.

Some patients told us that they found the availability of telephone consultation very useful. They said these appointments gave them the opportunity to ask questions about their care which could be answered quickly without taking up a longer face to face consultation. We were also told that when a patient asked to be called back at a specific time the GPs made every effort to comply with the patient's request.

GPs and nurses we spoke with were aware of their responsibilities in relation to applying the Mental Capacity Act 2005 (MCA). We were given an example by one of the GPs of how they used advocates to support a patient with dementia. One of the GPs had developed a more detailed knowledge of the application of the MCA and was available to colleagues for advice when required.

The practice offered teaching and learning for student GPs. There was information on the practice website and in the waiting room advising patients that GPs in training may be present during consultations. It was made clear that if a patient did not wish the doctor in training to be present they could withhold consent.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice had a limited number of disabled parking spaces available. Patients requiring the use of these called ahead to enable staff to open the barrier to these spaces. The practice was accessible to patients with mobility difficulties and a toilet with suitable facilities was available. The availability of ground floor consulting and treatment rooms was limited. However we were told, and patients confirmed, that GPs and nurses switched rooms to consult and treat patients who had difficulty getting up and down stairs. The practice had access to an efficient translation service should patients require it. An induction loop to amplify voice was available for patients with a hearing impairment. Staff told us that patients decided if they required an urgent appointment. This removed barriers to treatment and consultations. GPs offered consultation and advice by email, for patients who preferred this method. This showed the practice was sensitive to meeting patient's needs.

The practice had a system in place with secondary care providers to ensure information was exchanged efficiently when a referral was made or when results where available. Any action requested by the hospital or Out of Hours (OOH) service was communicated to the practice.

Access to the service

Alternative methods of booking appointments were available. Patients could book by telephone, in person or online. Appointments were available on two evenings each week and on Saturday mornings. Telephone consultations were also available. Double appointments could be booked upon request or on the advice of the GP. Patients told us they did not have problems accessing appointments unless they chose to wait to see a particular GP. The patients we spoke with were very positive about obtaining an appointment on the day they called. We saw that the practice adjusted the mix of pre bookable and on the day appointments to meet peaks of demand. For example, there were more on the day appointments on a Monday morning.

The hours when medical support was available were clearly displayed at the practice and on the website. When the practice was closed there was an answering message which directed patients to the out of hours service. However, some of the patients we spoke with were not aware of the procedure they should follow to obtain medical advice and treatment when the practice was closed. There was a risk that patients would avoid seeking treatment or attend the hospital emergency department because they did not know there was an out of hours (OOH) service available. We told the practice manager and the GPs about this and they assured us they would display prominent information on how to access out of hours services both in the practice and on their website.

There was a patient information leaflet available at reception and this was given to all new patients. It contained details of practice opening times and the services that were on offer in the practice. Further Information also included about the members of the practice team and how to make an appointment. The website provided information such as, the different clinics and services offered by the practice. This meant patients who used the service were given appropriate information and support regarding their care or treatment.

Meeting people's needs

Patients with a learning disability were registered with one named GP. The GP was able to co-ordinate the care for this group of patients and build a detailed knowledge of their health needs.

We saw systems were in place to refer patients for specialist care and support. Patients we spoke with who had been referred to hospital doctors told us that they had been involved in the decision to seek hospital care. We heard that referrals were dealt with in a timely and efficient manner.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person handling all complaints in the practice. The full complaints procedure was not displayed in either the practice leaflet or on the practice website. However, brief guidance on who to contact to lodge a complaint was available from these sources. Patients we spoke with were unaware of the complaints procedure although they told us they were pleased with the services they received and had not felt the need to raise any concerns or complaints.

We reviewed the summary of complaints received in since 2013. All complaints received had been investigated in full

Are services responsive to people's needs?

(for example, to feedback?)

and responses made to the complainant in accordance with the practice policy. We saw that in some cases the GPs responded personally to complaints about clinical care. When a complaint was referred to a professional body a detailed case folder was prepared.

We saw notes of meetings that showed us complaints were reviewed by the clinical team and lessons learnt from complaints were discussed and recorded. We did not see that learning from complaints was shared with the wider practice team.

Are services well-led?

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

Our findings

Leadership & Culture

All the staff we spoke with were focussed on ensuring patients could access timely medical advice and support. GPs were committed to delivering quality care and meeting the needs of all groups of patients. We saw minutes of a strategy review meeting that had been held in October 2013. This showed us that the practice was looking at ways of further improving the service they currently offered. For example GPs identified the need to synchronise medical reviews for patients with multiple long term conditions. We saw that work was underway to achieve this.

Governance Arrangements

A range of meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. Significant events and complaints were shared with the practice team to ensure they learnt from them and received advice on how to avoid similar incidents in the future. GPs led on specific areas of both clinical and general management and staff we spoke with were aware of which GP was responsible for which area. Management responsibilities were delegated to team leaders and staff clearly identified with their own team manager. However, staff told us they could go to either the practice manager or a GP if they needed additional support and advice.

The practice had a range of comprehensive policies and procedures covering a wide spectrum of topics. For example safeguarding, infection control and complaints handling.

There was an information governance policy in place and we saw that the practice had quality assured the processes in operation for use and storage of patient data. One of the GPs took responsibility for information governance.

Systems to monitor and improve quality & improvement (leadership)

We looked at a range of clinical audits that had been undertaken in recent years. We saw that audits, for example an audit of skin cancers, were very relevant to the health issues faced in the Oxfordshire area. We also saw that prescribing audits identified actions to be taken for further improvement and that these were repeated to confirm the action had been taken. Other audits were undertaken. For example, on success rates of cervical cytology tests.

Patient Experience & Involvement

The results of the national GP patient survey 2013 for this practice were within the CCG and national average. 80% of 114 patients said they would recommend their GP surgery and 85% of 114 patients rated their appointment experience as good or very good. The practice manager and GPs were aware of the feedback from patients on the NHS choices website. We were told that analysis of the comments had taken place. One of the comments related to lack of alternative types of appointment. We saw there was a variety of appointment options including on the day, booked in advance and telephone consultations available. We saw that the practice had a suggestion box which had been taken out of use. It was located in the entrance hall and had been subject to misuse. We discussed the opportunity for patients to offer suggestions with the practice manager. They told us they would look at alternative points in the practice to relocate the suggestion box.

Staff we spoke with told us they were able to access GPs and managers for advice and support when they needed to. There were a range of staff meetings held and staff said they were able to contribute to them. Staff felt they were listened to and their ideas and suggestions were considered. We were told that a member of staff had been involved in dealing with a complaint. Their ideas about how the complaint was dealt with resulted in a change in the complaints procedure.

Practice seeks and acts on feedback from users, public and staff

The practice had a patient participation group (PPG). A group set up to gain patients views and involve them in the practice and service development. We spoke with some of the members of this group. They told us they met with representatives of the practice and felt able to contribute their views about the services offered. We saw that the PPG had been involved in developing the action plan arising from the practice patient survey. The results of the practice survey showed that the majority of patients were happy with the services they received. We saw that an action plan had been developed to address the comments received during the survey. The practice was working on the actions

Are services well-led?

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

and we saw that some had been completed. For example an additional chemist had been added to the locations patients could collect their prescription from. We were also told that the PPG had supported the practice when they sought to move to a purpose built health centre but the campaign had not been successful.

Management lead through learning & improvement

The GPs recognised the importance of involvement in practice clinical and general management. All GPs were partners. We saw that the practice had recruited a new partner, who was due to start soon. Another partner had just reduced the hours they worked. Succession planning was in evidence.

A performance review system was in place. This referred to all staff receiving an annual appraisal. Some staff told us their appraisal had not taken place every year.

Nursing staff told us, and we saw evidence to confirm, they undertook relevant training to maintain their professional registration. The senior nurse had a system to check that registration was current which would ensure nurses were fit to practice.

One of the GPs hosted training events which covered a wide range of clinical topics. The GPs and nurses were invited to attend along with staff from neighbouring practices.

Identification & Management of Risk

The practice had taken a range of measures to identify, assess and manage risk. For example there was a fire risk policy and a professionally completed fire risk assessment. We saw that action identified in the assessment, for example fitting additional fire exit signs, had been taken We also saw a current control of infection policy and procedure. There was a health and safety policy dated 2013 however the risk assessment for the building that supported the policy was four years out of date.

Recall systems for patients who required regular health checks were evident. There were systems in place to follow up any patient who failed to attend for their checks.

Appropriate criminal record checks had been undertaken on staff to ensure they were safe to work at the practice.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had a lower than average number of older patients registered compared to the rest of Oxfordshire. The Quality and Outcomes Framework (QOF) data we reviewed showed good performance in managing long term medical conditions associated with patients over the age of 75. The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients.

Patients over the age of 75 were allocated a named GP. The patient's care and treatment needs would be known and followed up by one GP.

We saw that arrangements were in place to provide flu vaccinations and other vaccinations appropriate to this group of patients. If a patient was unable to attend a flu vaccination clinic they could attend at a time that was convenient to them. If the patient was unable to attend the surgery arrangements were supported to administer their vaccinations in their own home.

Home visits were arranged for the frail elderly to avoid them having to make difficult journeys to the practice. The practice did not support patients living in any nursing or care homes but GPs told us they would be happy to do so if requested.

There was a system in place to communicate information relating to end of life care to the Out of Hours service.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice supported patients with long term conditions. Disease registers were maintained that identified these patients. There were recall systems in place to ensure patients received monitoring and support. One of the practice nurses had identified patients with more than one long term condition and was working on a system to carry out a co-ordinated follow up for them. This would help the patient avoid multiple appointments with nurses and GPs.

We were told that when a GP diagnosed a long term condition they made an entry in the patient record which would establish the need for a regular review. We found that when a patient joined the practice with a pre-existing long term condition this was entered in their notes and a recall for annual review was set up.

The GPs followed national guidance for reviewing all aspects of a patient's long term condition because recommended care templates were in use. We saw that the practice achieved over 99% of the clinical targets for care of patients in this group. If a patient did not attend for their review there was a system in place to remind them of the importance of their health check. We saw that this group of patients were offered an annual flu vaccination.

The practice offered clinics for patients with long term conditions run by practice nurses. We saw that the nurses who managed these clinics had received additional training specific to the care needs of this group. For example training to support patients with diabetes. However, if attending the clinic was not convenient the patient could book to see either the appropriately qualified nurse or their GP for their review at a time that suited them.

GPs offered their e-mail address to patients with long term conditions. Patients who had a question about their treatment or care could e-mail their GP with their question or concern if they felt they did not need to be seen for an appointment.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice delivered services appropriate to the needs of mother, babies, children and young people. Systems were in place to invite parents or guardians to bring babies and young children for childhood immunisations. We saw that immunisation take up was over 90% for all immunisations. Nurses who were not fully trained and experienced in administering childhood vaccinations did not do so until their competency was checked. There were records showing that nurses attended relevant training in administration of childhood vaccinations.

Mother and baby health checks were carried out and there was a system to alert Health Visitors if the mother and baby did not attend.

There was close liaison with the college nurses at the university. Sexual health clinics and counselling services were available for the younger university students. Practice nurses told us they gave family planning advice to university students on a regular basis. Students were able to book appointments at times that they found suitable. Close liaison with the university college nurses and student support services was in place.

Expectant mothers were able to see their midwife at the practice and there were systems in place to support liaison between GPs and midwives to ensure care for expectant mothers was co-ordinated.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice offered a range of services to patients of working age and those recently retired. For example, there was a visiting physiotherapy service. Counselling and sexual health clinics were available and family planning advice was offered by practice nurses.

Access to a variety of appointment types was available. Evening surgeries ran on two evenings a week and a Saturday morning surgery was held. If patients found it difficult to attend the surgery they could request a telephone consultation. Appointments could be booked online. The practice had a higher than average number of patients of working age. This was due to supporting 12 colleges at Oxford University. E-mail and telephone consultation services were available which offered alternatives to patients who found it difficult to find the time to attend the practice.

Where electronic communication was available to specialist services this was used to avoid the need for this group of patients to attend further appointments at hospital. For example photographs of suspected skin complaints could be sent to the dermatologists for a diagnosis.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice recognised the needs of and offered services to patients in vulnerable circumstances. There were contracts in place to deliver medical services to a bail and probation hostel.

A Citizens Advice Bureau advisor attended the practice to offer benefits advice to patients on low incomes.

There were very few patients with a learning disability registered with the practice. One GP took responsibility for caring for these patients and we saw that they received an annual health check-up.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice offered a range of services to patients experiencing mental health problems.

Patients were referred to counselling services when appropriate. A range of leaflets detailing local self help and support groups was available.

The practice took an active role in supporting patients with drug and alcohol addiction. Shared care agreements were in place with the local addiction team and a nurse specialist in addiction treatment visited the practice to support patients. Some of the GPs had specialist expertise in working with patients with mental health problems.

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.

This section is primarily information for the provider

Enforcement actions

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.