Langford Medical Practice

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.

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Overall summary

Langford Medical Practice is a GP practice situated in Bicester in Oxfordshire and has 9,238 registered patients. The practice also has a branch surgery that dispenses medicines. The dispensing practice is based in Ambrosden, a village in Cherwell, Oxfordshire. It is approximately 2.5 miles away from the practice. The two practices share the same patient list.

The practice provided a range of services for patients. We spoke with patients about their experiences of care at this practice and also received written feedback from patients about the quality of services. All patients gave positive feedback about the practice and staff. The last patient survey, undertaken in 2014, showed us patients were satisfied with the care and treatment they received.

The practice opted out of providing out of hours primary medical services for its patients. Outside normal surgery hours Langford Medical Practice patients were able to access emergency care from an alternative out of hours provider.

Langford Medical Practice was patient-focused in its approach to care and treatment. The practice understood the different needs of the population it served and acted on these to ensure they supported patients appropriately. They had established links with the traveller community and had identified there was a high prevalence of depression in the local population. The practice used a variety of audits to assess and meet the needs of their patient population group. They completed audits for the prevalence and management of atrial fibrillation and chronic obstructive pulmonary disease (COPD) in July 2012 and July 2013. They used the information to ensure they had up to date data about their patient population group and make a decision if they needed to offer additional services. They also used the information to determine whether they had sufficient staff to meet the needs of patients with these conditions in their patient population.

The practice provided information and support to help patients understand their care and treatment and help them make informed choices. Patients were treated with dignity and respect. There was clear leadership within the practice, with a focus on continuous professional development. The practice actively sought comments and feedback from patients and acted on these to improve the service. However, we had some concerns related to the management of medicines and infection control. For example, the practice did not ensure expired medicines were not available to be used. There were not sufficient infection control audits to assist the practice identify, monitor and reduce the risk and spread of infection.

As part of the inspection we looked at management records as well as policies and procedures. We observed how staff cared for and interacted with patients and spoke with patients about their experiences of care at the practice. We also spoke with a range of staff, including GPs, nurses, a phlebotomist and administrative staff. We also met with the Oxfordshire Clinical Commissioning Group.

The provider was in breach of the regulations related to the management of medicines and infection control. We visited Langford Medical Practice, 9 Nightingale Place, Bicester, and Oxon, OX26 6XX. We also visited Ambrosden Surgery, Ambrosden, Bicester, and Oxon, OX25 2RH where there was a dispensary.

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 followed safeguarding procedures to protect patients at risk of abuse and there was learning from incidents and accidents to improve patient care. However, the management of medicines and the monitoring and documentation of infection control measures required improvement.

Medicines and prescription pads were not transported or stored securely. Assurance could not be provided that medicines transported between sites were kept within their recommended temperature ranges. Patients could therefore be given medicines that were no longer fully effective.

The service did not maintain appropriate systems to assess the risk of and to prevent, detect and control the spread of infection. The practice was seen to be clean but there were not sufficient infection control audits to assist the practice to identify, monitor and reduce the risk and spread of infection.

Are services effective?

The practice was effective. The practice delivered care and treatment in line with recognised guidance and best practice. They used data to analyse and improve outcomes for patients. Staff received appropriate training to ensure delivery and development of their role in the practice. There was an effective system in place to ensure staff received yearly appraisals. There had been a range of clinical audits, which had resulted in improvements to patient care and treatment.

Are services caring?

The service was caring. Patients experienced care, treatment and support that met their needs and protected their rights. All of the patients we spoke with or those who responded to our comment cards were complimentary about the staff team. They said they were involved in decisions about their care and treatment. They described the team as caring, kind, efficient and helpful. We observed warm and compassionate interactions with patients from all members of the staff team.

Are services responsive to people's needs?

The practice was responsive to patients' needs. The practice responded quickly to improvements suggested by patient participation groups. The practice understood the different needs of

Summary of findings

the population it served and acted on these to ensure they supported patients appropriately. Patients complaints and comments were used to improve services and outcomes for patients.

Are services well-led?

Improvements in the management of the practice are required in relation to the governance arrangements and the identification and management of risk.

The GP partners and the practice manager encouraged ongoing training and development for all staff. The GP partners demonstrated strong and visible leadership. They empowered staff to take on responsibility. The practice ensured they received and acted upon feedback from patients to improve the service.

There were governance systems in place but these were not fully effective. The practice did not identify and respond to risks promptly to ensure the safety of patients. Patients were not given sufficient information about how to open emergency exit doors and emergency lighting tests and fire evacuation drills were not completed. Infection control audits had not been undertaken to assess the risk of and to prevent, detect and control the spread of infection.

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 operated a system where patients who were 74 years old and above were allocated a named GP. The GPs conducted home visits and visited patients at a local nursing homes. The practice had undertaken recent work to identify and assist patients who had caring responsibilities for older people.

There were quarterly gold standard framework meetings with multi-disciplinary team consisting of community district nurses, mental health nurses, health visitors to discuss and meet the needs of patients with palliative care needs.

People with long-term conditions
Patients with long term conditions were well supported to manage their health, care and treatment. They benefitted from effective information and guidance from the practice about the management of their conditions. The practice offered a range of clinics during the week and at weekends run by specially trained nurses for patients with long term health conditions.

Mothers, babies, children and young people
The practice had a variety of clinics to assist mothers, babies and young children. Staff worked closely with the local health visitors and community midwives to identify children who were at risk and ensure they received appropriate care and treatment. Parents we spoke with told us the staff had good communication skills and were good at explaining care and treatment options to younger patients.

The working-age population and those recently retired
Working patients were able to receive advice and support outside traditional working hours. There were early morning appointments and the practice opened until 6.30pm every evening. The practice offered Saturday appointments for patients who had diabetes with the nurse practitioner.

People in vulnerable circumstances who may have poor access to primary care
Staff had developed links with the traveller community. They assisted travellers who could not read by carefully describing the

Summary of findings

medicine regime and the treatment options to ensure they understood them. The practice had a system to ensure patients with a learning disability were identified and received an annual health check.	
People experiencing poor mental health The practice was aware of the high prevalence of depression in its patient population and was proactive about working closely with local mental health services to ensure patients were well supported. Staff were educated and informed about local support services and they provided a range of information to patients. The appointment system enabled patients with poor mental health to be seen quickly.	

Summary of findings

What people who use the service say

We spoke with 17 patients and received 41 comments cards from patients who had visited the practice in the previous two weeks. Patients were positive about the staff and the care and treatment they received and spoke highly of all the staff. All patients told us they had enough time to discuss their concerns and were given information and support to understand their condition and the treatment options. Patients were very complimentary about the GPs and other staff in the practice.

The practice results for the national GP patient survey in 2014 were higher than the national average. Information on the practice website showed us 80% of patients were very satisfied with the practice and 20% of patients were fairly satisfied with the practice.

Areas for improvement

Action the service MUST take to improve

The practice must ensure that medicines transported between sites are transported securely and maintained within their recommended temperature ranges.

The practice must ensure the policy for monitoring the expiry of medicines is followed.

The practice must ensure that medicines and prescription pads which are completed by hand are stored securely.

The practice must ensure all repeat prescriptions are signed prior to dispensing.

The practice must maintain appropriate systems to assess the risk of and to prevent, detect and control the spread of infection.

Action the service SHOULD take to improve

The practice should consider that all dispensary staff undertaking the final dispensary accuracy check complete a recognised training course.

The practice should ensure that requests for repeat prescriptions are stored confidentially.

The practice should have sufficient governance systems to identify and respond to risks promptly to ensure the safety of patients.

The practice should identify and respond to fire risks promptly to ensure the safety of patients in emergencies.

The practice should ensure their letters in response to complaints made by patients offered them an opportunity to meet face-to-face and contained details of how to make referrals to the Ombudsman.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

There were quarterly gold standard framework (a model of best practice) meetings with multi-disciplinary team consisting of community district nurses, mental health nurses, health visitors to discuss and meet the needs of patients with palliative care needs.

There were appointments for patients offered on a Saturday to patients with diabetes by a nurse practitioner.

A GP partner had developed a rheumatology out-patients' service and saw patients once a month at the practice.

Langford Medical Practice

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, a second CQC inspector, an Expert by Experience (an Expert by Experience has personal experience of using or caring for someone who uses a health, mental health and/or social care service) and a Pharmacist.

Background to Langford Medical Practice

Langford Medical Practice is located in Bicester, a town in Oxfordshire. There is another dispensary practice which shares the same patient list and is located in Ambrosden, a village in Cherwell, Oxfordshire. It is approximately 2.5 miles away from the practice.

The practice provides a range of primary medical services to approximately 9,238 patients. Patients are supported by five GP partners, salaried GPs, nurses, a health care assistant, a phlebotomist (someone who is trained to take blood samples) and administration staff. The practice is a member of the Oxfordshire Clinical Commissioning Group.

The practice opted out of providing out of hours primary medical services for its patients. Outside normal surgery hours Langford Medical Practice patients were able to access emergency care from an alternative out of hours provider.

Langford Medical Practice was patient-focused in its approach to care and treatment. The practice understood the different needs of the population it served and acted on these to ensure the service supported patients appropriately. They had established links with the traveller community and had identified there was a high prevalence of depression in the local population. The practice used a variety of audits to assess and meet the needs of their patient population group. They completed audits for the prevalence and management of atrial fibrillation (abnormal heart rhythm associated with congestive heart failure) and chronic obstructive pulmonary disease (COPD) in July 2012 and July 2013. They used the information to ensure they had up to date data about their patient population group and make a decision if they needed to offer additional services. They also used the information to determine whether they had sufficient staff to meet the needs of patients with these conditions in their patient population.

The address of Langford Medical Practice is 9 Nightingale Place, Bicester, Oxfordshire, OX26 6XX. Ambrosden Surgery address is, Ambrosden, Bicester, Oxon, OX25 2RH.

Why we carried out this inspection

We inspected this out-of-hours service 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

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?

Detailed findings

- 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.

Before visiting, we reviewed a range of information we had received from the GP practice and asked other organisations to share their information about the service. We carried out an announced visit on 9 July 2014. During our visit we spoke with a range of staff. These included GP partners, salaried GPs, nurses, a health care assistant, a phlebotomist (someone who is trained to take blood samples) and administration staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event/reviewed comment cards where patients and members of the public shared their views and experiences of the service. We met with Oxfordshire clinical commissioning group (CCG), NHS England and Oxfordshire Healthwatch.

We carried out an announced visit on 9 July 2014. .

During our visit we spoke with a range of staff, including GP partners, salaried GPs, nurses, a health care assistant, a phlebotomist (someone who is trained to take blood samples) and administration staff and spoke with patients who used the service.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

The practice followed safeguarding procedures to protect patients at risk of abuse and there was learning from incidents and accidents to improve patient care. However, the management of medicines and the monitoring and documentation of infection control measures required improvement.

Medicines and prescription pads were not transported or stored securely. Assurance could not be provided that medicines transported between sites were kept within their recommended temperature ranges. Patients could therefore be given medicines that were no longer fully effective.

The service did not maintain appropriate systems to assess the risk of and to prevent, detect and control the spread of infection. The practice was seen to be clean but there were not sufficient infection control audits to assist the practice to identify, monitor and reduce the risk and spread of infection.

Safe Track Record

The practice had an incident reporting process which was known to all staff we spoke with. There were documented examples of safety related incidents which had occurred in the practice and been appropriately responded to by the staff team. For example they identified wheel chair users could be at risk using the ramp so they ensured patients were advised how to use the ramp safely. There was a management structure for the staff to report any concerns and staff told us they felt confident in raising concerns.

The practice was registered with a central alerting system. Safety alerts like those about the recall of medicines were sent to the practice manager and cascaded to all staff. Staff we spoke with were aware of the incident reporting process and understood how to respond to and report safety related incidents. The practice manager told us that the GP partners also shared medical alert information with other GPs and nurses in the practice to ensure patient safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There was a system in place to analyse significant events to prevent similar incidents from occurring in the future. For example when a controlled drug expired in 2003 was found in the emergency medication box in 2014, there was evidence of significant event analysis and a plan for ensuring remedial actions were implemented. This included a new system for monitoring the contents of the boxes which included documented checks. A GP Partner told us they found the system useful.

The practice discussed significant events at their weekly meetings. The minutes of these meetings showed us events were discussed when they occurred and then again one year after the event to review the implementation success. Any feedback to clerical and administrative staff was added to a shared area on the practice computer server. We saw examples where the practice manager directed staff to read the information by email to make sure they were aware of any changes.

Reliable safety systems and processes including safeguarding

Patients were able to talk to a GP on the phone or make an appointment to review their test results. For example blood test results. Patients we spoke to confirmed the results were reviewed quickly and they were given sufficient information about any further treatments they required.

Children and adults were protected from the risk of abuse because the practice took steps to identify and prevent abuse from happening. There were systems in place to identify patients who could be at risk of abuse but there were some omissions. For example, there was no documented safeguarding policy so staff did not have written information about the procedure to follow if they suspected or witnessed any concerns. This could result in a delay to patient referrals to the local authority safeguarding teams.

All staff had received an appropriate level of training for protecting vulnerable children and adults at their induction and then updates via e-learning. The GP partner who was the safeguarding lead had level three training for children and had sufficient training in protecting vulnerable adults to effectively meet the demands of their role. The other GPs had level two training. The safeguarding lead told us about recent referrals they had made to social services to ensure patients' safety. They demonstrated they knew how to protect children and adults from abuse.

Monitoring safety and responding to risk

Are services safe?

The practice did not always identify and respond to risks promptly to ensure the safety of patients. We saw that a fire risk assessment had been carried out but it did not indicate when the date of next review was due. We saw fire alarm tests were carried out and firefighting equipment was maintained with the most recent check being April 2014. However, emergency lighting tests and fire evacuation drills were not carried out. Emergency exit routes and door checks were made daily and recorded. However, all the emergency exit doors leading outside were found to be secured by a twist lock and handle with no pictorial guide to how to operate the lock. The lock could therefore be difficult for patients to open if there was an emergency. In this respect the practice did not follow the HM Government Fire Safety Risk Assessment guidance for healthcare premises.

The practice had undertaken a Legionella risk assessment in February 2014 which identified actions required to minimise the risk of harm to patients from Legionella. The practice manager told us the practice had not fully implemented the action plan. The delay in completing the identified actions from the risk assessment put patients at potential risk of harm from Legionella.

Equipment and medicines were available for use in a medical emergency. The emergency medicines and automated external defibrillator (AED) were checked regularly to ensure they were in date and in working condition. We saw evidence of these checks. Staff had received recent basic life support training. We spoke with staff and we saw records to confirm staff had been trained in how to deal with medical emergencies which included basic life support.

Medicines management

We visited the dispensary practice which was used by patients who lived more than one mile from the nearest pharmacy and the practice itself, to look at the way medicines were managed.

The practice had policies and procedures for staff covering the supply of medicines. Medicines were purchased from approved suppliers. Medicines requiring refrigeration were stored in specific refrigerators for medicines. The minimum and maximum temperatures of these refrigerators were recorded and acted on when outside of the recommended temperature range. Emergency medicines were available.

Expiry dates were pro-actively monitored; however we found one product which had expired. The service was unable to tell us if the rooms where medicines were stored were within recommended temperature ranges.

Blank prescriptions to be completed by hand were left in an insecure manner and could be accessed by any member of staff and the public. The minimum and maximum temperatures were not recorded when medicines were transported by staff. Therefore the practice was unable to assure us that the medicines remained within their recommended storage temperatures and were fit for use.

The practice monitored the frequency of repeat prescribing requests from patients and escalated concerns to the GP. Repeat prescriptions including those for controlled drugs generated by practice staff were retrospectively signed by the GP after dispensing. The handing out of a dispensed medicine which is a Controlled Drug whilst the prescription has not signed by a GP is a contravention of the Misuse of Drugs Act 1971 and its associated regulations. The retrospective signing of FP10 prescriptions is a contravention of The National Health Services (Pharmaceutical Services) Regulations 2005 Schedule 2 Terms of service for Dispensing Doctors.

Where incidents involving medication were identified the practice logged and investigated the incidents. As a result of these investigations, processes had been changed to reduce the risk of incidents occurring again.

Cleanliness and infection control

The practice was seen to be clean but there were insufficient infection control audits to assist the practice to identify, monitor and reduce the risk and spread of infection. The practice had an infection control lead but the practice did not have an infection control policy or an annual infection control statement. The infection control lead confirmed that these had not been written. We were also told by the infection control lead that infection control audits had not been undertaken. Without these audits the practice could not demonstrate they met the requirements outlined in Department of Health's publication, The Code of Practice for health and adult social care on the prevention and control of infections and related guidance (2009).

Are services safe?

The practice had cleaning checklists which were followed by GPs and nurses. We were told visual checks made by the infection control lead had taken place but these were not recorded.

There was a clinical waste contract in place for the practice and the clinical waste bins could be secured shut.

We spoke with patients about the cleanliness of the practice. All of them told us they were happy with the environment and cleanliness. We noted all areas of the practice were visibly clean and tidy and the treatment and consulting rooms had clutter free work surfaces, which were easy to clean. The treatment room curtains were clean. Labels with dates for their replacement were seen on all curtains and all were within the use by dates.

Staffing and recruitment

There were sufficient staff to meet the needs of the local population. Patients we spoke with told us they could easily access GPs and nurses and did not have to wait long for appointments. Comments from patients in the comment cards included examples of when they had rung the practice to make an appointment with a GP and had got one on the same day. The Practice Manager told us staff retention was very good with only four staff leaving the practice in the last four years. In one case this was due to retirement.

The practice had a range of recruitment and selection procedures to ensure patients were supported by suitably skilled, qualified and experienced staff. We looked at four staff files, which contained information on pre-employment checks and met recruitment guidelines. We saw there was no documented recruitment policy to support the recruitment procedures. GPs, nurses and administrative staff had undergone criminal record check via the Disclosure and Barring Service (DBS) before they started work.

The practice maintained a group indemnity policy which covered all of their GP partners, practice nurses and health care assistants. It was not possible to verify the indemnity status of the salaried GP and the nurse practitioner as the practice held no record of their current indemnity cover. GPs entry on the performers register was not periodically checked (GPs and GP trainees need to be registered with NHS England Medical Performers register because if they are not on the register then they are not authorised to work). However we verified the entry of each of the GPs on the register on the day of inspection using the General Medical Council (GMC) website.

Locum GPs were booked by the finance manager on instruction from the GP partners. They told us they generally used GPs that they knew. They said they always asked for a copy of the GPs curriculum vitae (CV) and their GMC number. Their entry on the performers register was also checked before they started work at the practice.

Dealing with Emergencies

There was a disaster recovery plan in place which was reviewed in June 2014. This included planning for significant events that could affect the service. For example, staff sickness, fire and flood. We saw this plan in action on the day of our visit when the practice experienced a computer system failure. We saw staff revert to pre-printed patient lists and were told that the practice printed these off every evening should their computer system fail overnight.

Equipment and medicines were available for use in a medical emergency. The emergency medicines and automated external defibrillator (AED) were checked regularly to ensure they were in date and in working condition.

Equipment

We saw records to confirm practice equipment was maintained and calibrated in line with manufacturers' guidelines. For example, electrical equipment was portable appliance tested (PAT).

Are services effective?

(for example, treatment is effective)

Our findings

The practice was effective. The practice delivered care and treatment in line with recognised guidance and best practice. They used data to analyse and improve outcomes for patients. Staff received appropriate training to ensure delivery and development of their role in the practice. There was an effective system in place to ensure staff received yearly appraisals. There had been a range of clinical audits, which had resulted in improvements to patient care and treatment.

Effective needs assessment, care & treatment in line with standards

Care and treatment was delivered in line with recognised best practice standards and guidelines. For example GP and nurses followed the relevant National Institute for Health and Care Excellence (NICE) guidelines for long term conditions management. They also followed the British Society for Rheumatology and British Health Professionals in Rheumatology guidance. One GP at the practice was a specialist in this field. A GP told us they kept up with new guidance, legislation and regulations and regularly discussed these at their own meetings and at their meetings with other GP practices.

The GPs had undertaken training in the Mental Capacity Act 2005 (MCA) to assist them to support patients with diminished mental capacity. They demonstrated knowledge of the issues involved in making mental capacity assessments to ensure patients' safety.

Patients' needs and any risks associated with their treatment were discussed at their initial consultation with a GP. A GP told us treatment plans were agreed with the patient and then recorded. Patients we spoke with confirmed this was the case.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audits. Examples of clinical audits included an audit of anti-psychotic medicines. The practice was aware about the high prevalence of depression in its patient population. They recently conducted an audit of patients on anti-psychotic medication to ensure safety and check the accuracy of the register for patients with mental health needs. They reviewed the audit results and took action to develop the practice. For example they offered space for a mental health service to deliver clinics in the practice so patients with mental health concerns had easy access specialist assistance.

The practice achieved high results in the majority of domains in the most recent Quality and Outcomes Framework (QOF) in 2012/13. The QOF is a voluntary incentive scheme for GP practices in the UK. We spoke with a GP partner about the outcomes in the QOF. They were aware of QOF data which highlighted some concerns about outcomes related to atrial fibrillation (abnormal heart rhythm associated with congestive heart failure) and chronic obstructive pulmonary disease (COPD). A senior partner told us this was due to the high number of younger patients in the local population who were less likely to have these conditions. The practice completed audits for the prevalence and management of these conditions in July 2012 and July 2013. They used the information to ensure they had up to date data about their patient population group and make a decision if they needed to offer additional services.

Effective Staffing, equipment and facilities

There was effective induction training for recently recruited staff. We saw records of induction on staff files. Reception staff spoke positively about their induction.

There was a system in place to ensure staff received yearly appraisals. We spoke to four staff and they confirmed they had appraisals annually. The GP partners took responsibility for the majority of staff appraisals. We saw the content of the appraisals was inconsistent. For example in three of the five appraisals we read staff did not have objectives for the following year to assist their service delivery to patients.

Continuing professional development and training was available for GPs and nurses. The training schedule for all staff at the practice confirmed mandatory training had taken place on areas like cardiopulmonary resuscitation (CPR), health and safety and safeguarding children. Two reception staff members we spoke to confirmed additional training in areas like customer care had taken place. They were able to describe how they used the training to improve their communication with patients.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice worked closely with other health and social care providers to coordinate care and meet patients' needs. For example, there was regular recorded involvement with health visitors on the weekly morning clinical meetings. There was also pre and post natal shared care with midwives who delivered clinics from the medical centre. Patients we spoke with who had received health visitor and midwives support from the practice were complimentary about the service they received.

The practice worked closely with organisations that supported patients who had mental health needs. A mental health service to delivered clinics in the practice. Patients who mentioned this service on the comment cards felt this easy access was beneficial to them.

There were quarterly Gold Standard Framework (a model of best practice) meetings with multi-disciplinary team consisting of community district nurses, mental health nurses, health visitors to discuss and meet the needs of patients with palliative care needs.

Health Promotion & Prevention

The practice had health related information leaflets in the waiting area to assist patients. These included information about smoking cessation and diabetes management. We saw three patients reading this material whilst waiting to see a GP. One patient told us they found the information useful and they intended to take the leaflet home to contact the services listed for further assistance with their health condition.

Information on the practice website informed patients that all GPs and nurses were available for lifestyle advice and health promotion. For example they had nurse-led clinics for coronary heart disease, stroke, hypertension, asthma, COPD and epilepsy. A nurse told us they talked with patients about self-management of their long term health condition and together developed management plans.

The practice website also had information for patients which included self-help advice about medical conditions. These included links to other relevant websites and support groups along with information about the condition. Four patients told us they used the website to access services in their local area.

The practice had a system in place to ensure patients had regular health checks. For example, all new patients to the practice were offered nurse led patient medicals. Smoking cessation and weight management advice was provided by the practice nurse and GPs who made referrals to other services where appropriate. There were also flu clinics offered on a Saturday to ensure patients who worked in the week could attend.

The practice was proactive about promoting patients health. They routinely wrote to female patients between the ages of 25 to 65 to invite them to make an appointment for a cervical smear test. Patients aged between 25 and 49 were offered a smear test every three years, and all those aged 50-64 every five years. Patients were reminded on the practice website to check with the practice nurse if they felt an examination was necessary when moving into the area. Patients were informed of their results in writing, with an explanation of the results so they could interpret them. Patients we spoke with knew about these tests and told us they had found them useful in the early detection of ill health.

Are services caring?

Our findings

The service was caring. Patients experienced care, treatment and support that met their needs and protected their rights. All of the patients we spoke with or those who responded to our comment cards were complimentary about the staff team. They said they were involved in decisions about their care and treatment. They described the team as caring, kind, efficient and helpful. We observed warm and compassionate interactions with patients from all members of the staff team.

Respect, Dignity, Compassion & Empathy

The practice provided a compassionate, friendly and caring service. All 17 patients we spoke to on the day of our visit were complimentary about the staff. They described staff as helpful, kind, efficient and caring. All staff we spoke with told us the practice was patient centred and patients' care was of paramount importance. We observed staff treating patients with dignity and respect. We saw the reception staff made sure patients waiting to check in or make an appointment were assisted promptly. Reception and administrative staff said they were able to get to know the patients well over a period of years and they were well integrated into the local community.

Eight of the 17 patients we spoke with were positive about the availability of the chaperone service to ensure their privacy was respected during consultations. One patient had on one occasion requested a chaperone and the others knew they could request one if they needed to.

We saw the practice 'Confidentiality (teenagers) Policy'. We spoke with a GP partner who demonstrated an understanding of confidentiality for patients who were under 16 years old. They told us they had experience of using Gillick competency when assessing or providing care or treatment to children. Gillick competency is a framework used to determine if a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge.

We saw confidential information was not always stored securely. In reception there was a repeat prescription request box which was open and visible to members of the public. This included sensitive patient information which could be seen by other patients.

Involvement in decisions and consent

There was a patient centred approach to care and treatment from all staff. Patients with long term conditions were well supported to manage their health, care and treatment. Detailed care planning was in place for patients with long term conditions such as diabetes and asthma. Patients we spoke with told us they were involved in making decisions about their care and treatment. They said they were given sufficient information to enable them to make informed decisions about treatment and they were offered options from which to choose. The practice operated a 'choose and book' system, which meant patients were able to choose where they wanted to be referred to for specialist care and treatment.

A GP partner who had undertaken training in the Mental Capacity Act 2005 (MCA) told us how they completed mental capacity assessments to assess patients' ability to give consent to treatment. They worked closely with relatives and services involved in the care of the patient to ensure the patients best interests were met if they did not have sufficient mental capacity to make their own decisions or give consent to treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive to patients' needs. The practice responded quickly to improvements suggested by patient participation groups. The practice understood the different needs of the population it served and acted on these to ensure they supported patients appropriately. Patient's complaints and comments were used to improve services and outcomes for patients.

Responding to people's needs

The practice understood its patient population group and was responsive to their needs. Staff told us they had few older people registered with the practice. The largest proportion of patients were young people of working age with a high number of mothers and babies. The patient population group had almost twice the national average birth rate. The practice had services in place to demonstrate they were responsive to the needs of this population group. For example they had a comprehensive breastfeeding policy where they made the waiting room area accessible to feeding mothers and provided privacy for those who wanted it. The practice held weekly meetings with health visitors to improve care for children. There were also three maternity clinics each week.

Even though the numbers of older people in the practice was relatively small the practice was responsive to the needs of older people. For example all people aged over 75 were able to gain same day telephone access to the GP in order to avoid unplanned admissions to hospital. Older patients we spoke with told us they had access to home visits. A GP told us If they were concerned about the health of a patient they visited them daily. For example over a recent bank holiday a GP saw a patient on the Friday and then visited the patient every day over the bank holiday weekend to check on their welfare.

The practice was aware of and had links with a variety of other healthcare services to support its patients. Staff had links with specialist nurses in learning disabilities, mental health and long term conditions so patients had access to up to date information and treatments. The practice had responded positively to feedback from the patient participation group (PPG) and individuals. For example, patients did not feel there was sufficient reading material in the waiting room. In response, the practice purchased a large magazine rack and supplied a variety of magazines including items for children. Other patients requested a texting service for appointments which was provided.

The practice manager told us patients with long term conditions were offered double appointments when they were experienced more than one health condition so they were only being called once per year. Patients we spoke to told us they found this useful. Health checks were being delivered by the health care assistants to assist the practice identify sufferers of chronic disease.

There was Information on long term conditions in the waiting room. A GP partner told us the new computer system would allow GPs to print leaflets directly from the patient record. This would assist patients to develop strategies to manage their condition.

Access to the service

The practice made efforts to ensure all areas of the premises were accessible to patients. The practice environment had been adapted to accommodate a variety of patient needs. There was wheelchair access and two toilet facilities which were accessible to patients with restricted mobility.

The practice operated an appointment system where appointments were booked on the same day they were requested. A GP partner told us one third of all appointments were pre booked. The other two thirds were available for same day appointments to assist patients see a GP quickly. There were also early morning appointments for patients. On two days in the week the practice opened at 7am in the morning. These appointments were available for patients who worked during the day or who could not visit the practice during working hours.

Each GP had four sessions a day of which three were used to see patients. The other part of the GPs' day was available for home visits. Each day a duty GP was available for emergency appointments and home visits. If patients required an emergency appointment they were asked to see either the duty GP or whichever GP was available. The practice manager told us patients who requested an emergency appointment were asked by receptionists the reason for the appointment. However patients were able to keep information private if they preferred. Four patients we spoke to confirmed this was the case.

Are services responsive to people's needs?

(for example, to feedback?)

The practice also offered late appointments until six thirty in the evening Monday to Friday and telephone appointments to ensure patients who worked were able to access advice and treatment. Patients gave us positive feedback about the appointment system. Fifteen of the 17 patients we spoke to on the day of our visit expressed satisfaction with the appointment system. They said they were always able to book an appointment on the day. The other two patients did not comment on the availability of appointments. The results of the most recent patient survey identified positive feedback from patients about the appointment system. In regard to the comment cards we received, 22 of the 41 we received provided feedback about the appointment system and all were positive telephone access to GP advice and support and access to appointments.

Patients also had the option of seeing a GP in the dispensing practice a short distance away if it was more convenient for them to do so. Patients told us they found it useful to have two sites.

Meeting people's needs

The practice promoted person-centred and coordinated care for patients. They worked closely with local hospitals to ensure they met the needs of patients with complex or multiple needs. The practice ensured patients who had attended hospital were offered follow up appointments at the practice. A GP partner told us they closely monitored patients' health after they had attended hospital. They updated their records promptly with any hospital correspondence.

The practice worked closely with patients from the travelling community to assist them to access and use the service. Patients from the traveller community were offered longer appointments and staff assisted then in the registration process to make it as accessible as possible. Staff members spoke warmly of their relationship with the traveller community.

Concerns and 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 who handles all complaints in the practice. There was a complaints information leaflet for patients to explain how they could make a complaint.

The patients we spoke with told us if they had concerns about their care they would not hesitate to raise them with staff. The practice manager told us they always spoke to patients at the time they made a verbal complaint. They said they asked patients how they would like to progress with the complaint and this approach normally allowed the situation to be resolved.

Complaints and comments were used to improve services and outcomes for patients. For example, we were told a complaint about information relating to a cervical smear test had resulted in the practice reviewing this information and making improvements.

The practice manager was responsible for managing the practice complaints process. We were told that sometimes the GP would also respond to complaints. We saw evidence the practice had investigated concerns and responded to them in accordance with its policy. Written complaints were encouraged by the practice. The practice manager acknowledged complaints within three working days of receipt and responded in full within 10 working days. The letters of response did not always offer patients an opportunity to meet face-to-face and also did not contain details of how to make referrals to the Ombudsman. None of the response letters gave details of how patients could forward their complaint to the Ombudsman.

The complaints log recorded subsequent actions taken and learning points. The complaints log also noted when information, outcomes and learning were fed back to relevant staff.

Are services well-led?

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

Our findings

Improvements in the management of the practice are required in relation to the governance arrangements and the identification and management of risk.

The GP partners and the practice manager encouraged ongoing training and development for all staff. The GP partners demonstrated strong and visible leadership. They empowered staff to take on responsibility. The practice ensured they received and acted upon feedback from patients to improve the service.

There were governance systems in place but these were not fully effective. The practice did not identify and respond to risks promptly to ensure the safety of patients. Patients were not given sufficient information about how to open emergency exit doors and emergency lighting tests and fire evacuation drills were not completed. Infection control audits had not been undertaken to assess the risk of and to prevent, detect and control the spread of infection.

Leadership & Culture

Staff we spoke with were clear about the ethos of the organisation. They described it as a family orientated practice which was caring, friendly and gave a good service to patients. The partners provided clear leadership within the practice. All the staff we spoke with told us they felt comfortable raising concerns and were confident they would be taken seriously and acted upon by the GP partners. Staff we spoke with told us the practice worked well as a team.

There were informal staff meetings three times during the day to ensure information was shared. There were also weekly clinical meetings and quarterly practice meetings. The clinical meetings included information sharing about patients. The practice meetings attended by all the staff team discussed wider issues about the practice such as training events.

We spoke with the GP partners about their long term strategy for the practice. They told us the practice manager was leaving shortly and would not be replaced immediately. There was a contingency plan in place with three existing senior staff forming a new management team. The partners attended local clinical commissioning group (CCG) meetings and regularly met with a group of eight local practices to discuss, amongst other matters, the long term vision and future of primary care in the area. At the time of the inspection the practice met with the CCG to discuss a range of options for the future.

Governance Arrangements

The governance arrangements mostly ensured individual roles and responsibilities in the practice were clear to all staff. The information governance lead/Caldicott Guardian roles were split between the practice manager and the finance manager (a Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.) We asked staff if they knew who to approach for advice if a concern arose and the majority of people we spoke with said they would go to the practice manager.

There were some concerns about information governance arrangements in relation to repeat prescriptions.

Repeat prescriptions including those for controlled drugs generated by practice staff were retrospectively signed by the GP after dispensing. This had not been identified or addressed by the practice management team.

The practice had also appointed leads who had specialisms in areas such as mental health, civil aviation authority medicals, GP training, long acting reversible contraception and rheumatology. All the staff we spoke with were clear about the GP specialisms The majority of policies and procedures we reviewed were in date and had been reviewed.

Systems to monitor and improve quality & improvement (leadership)

The practice used information from the most recent Quality and Outcomes Framework (QOF), to identify areas for improvement and scored highly across all areas. They employed a private company to conduct some clinical audits to ensure the accuracy of the QOF registers.

Patient Experience & Involvement

The practice had an active patient participation group (PPG). A PPG is a voluntary group of patients registered with the practice who represent patient views. We spoke with the coordinator of the PPG who told us the group worked positively with the practice. They told us the practice listened and was open to making any

Are services well-led?

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

changes the group suggested. For example, the practice had introduced text messages to remind patients of their appointments. All of the patients we spoke with told us they knew about the PPG. They told us could also make comments or suggestions on the website or via comments and suggestions box in reception.

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

All of staff we spoke with about whistleblowing (informing senior staff of concerns) told us they felt confident to whistleblow if poor or bad practice was identified. They felt confident any concerns they raised would be resolved by the GP partners and the practice manager. They told us they felt listened to and confirmed that their views and opinions were acted upon. A staff member told us about how the GPs were supportive of their training needs. They said the practice sometimes closed for an afternoon so they could devote time for training. They spoke of an inclusive atmosphere in the practice where the domestic staff were invited to training to ensure they were part of the team.

We saw evidence of staff involvement in a variety of meetings including practice, reception team, and clinical team meetings. Staff told us they often had open agendas so they could bring matters arising to the meetings. The meetings included clinical and non-clinical issues, information, and learning opportunities to ensure staff were fully informed.

Following the patient survey in 2014 the practice introduced a bead table for younger patients. Feedback from the PPG on the practice website confirmed it was so popular they were currently fund raising for another table.

Management lead through learning & improvement

The practice was a teaching practice and there were opportunities for continued professional development and training available for the GPs. One GP was a team leader at the Oxford Deanery which provides training to dentists and doctors in Berkshire, Buckinghamshire and Oxfordshire). The Deanery completed its own inspection visits to look at training in the practice. The practice showed us its most recent training practice report dated November 2013. We saw the recommendations of the report had been competed or were in the process of being completed by the practice.

The GP partners and practice management encouraged ongoing training and development for all staff. Staff we spoke with told us the practice used protected learning time and staff meetings to develop their knowledge and skills. They spoke positively about the learning opportunities within the practice.

Identification & Management of Risk

The practice used their daily meetings to identify and manage patient risks. We saw limited evidence of recorded risk assessments although all staff we spoke with confirmed risks were discussed on a regular basis. For example, they identified but did not formally record the risk to wheelchair users using the ramp to the practice. The practice had a business continuity plan and a risk register in relation to events that could affect provision of services. For example, staff sickness, fire and flood.

The practice did not identify and respond to risks promptly to ensure the safety of patients. For example, emergency lighting tests and fire evacuation drills were not carried out and patients were not given sufficient information about how to open emergency exit doors. The practice did not maintain appropriate systems to assess the risk of and to prevent, detect and control the spread of infection. The infection control lead told us that infection control audits had not been undertaken.

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

Summary of findings

The practice operated a system where patients who were 74 years old and above were allocated a named GP. The GPs conducted home visits and visited patients at a local nursing homes. The practice had undertaken recent work to identify and assist patients who had caring responsibilities for older people.

Our findings

There were quarterly gold standard framework meetings with multi-disciplinary team consisting of community district nurses, mental health nurses, health visitors to discuss and meet the needs of patients with palliative care needs.

The practice had a system to ensure every patient aged 74 years and above had a named GP within the practice. Patients aged over 75 years old had same day telephone access with a GP in order to avoid unplanned admissions to hospital.

We saw the practice maintained a register of carers to identify patients who had caring responsibilities. This included carers of older people and older people caring for others. A GP told us there were clinical system alerts for GPs to identify carers when they come for appointments. Carers were able to leave messages for doctors to call them back. Staff told us they did this to ensure carers were offered in depth support.

We saw the practice maintained a palliative care register. There were quarterly gold standard framework meetings with multi-disciplinary team consisting of community district nurses, mental health nurses, health visitors to discuss and meet the needs of patients with palliative care needs. The practice kept patients on their lists when they moved out of their area if they were receiving end of their life care as they told us it would be too disruptive to re-register elsewhere. This demonstrated a caring attitude to patients receiving palliative care.

The GPs undertook home visits and visited the local nursing homes. A GP told us the visits were conducted as needed and could be requested by either the patient or their carer. A GP told us these visits were often used by older members of the community. Some of the GPs in the practice were on the rota for their out of hours provider so they knew the patients very well and could offer continuity of care. All patients who commented on home visits in the comment cards were complimentary about the service and older people gave examples where a GP had visited frequently over a weekend period to ensure they were safe.

Older people could visit the dispensary practice rather than the main practice to get their medicines as the nearest pharmacy was more than a mile away from the practice.

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

Summary of findings

Patients with long term conditions were well supported to manage their health, care and treatment. They benefitted from effective information and guidance from the practice about the management of their conditions. The practice offered a range of clinics during the week and at weekends run by specially trained nurses for patients with long term health conditions.

Our findings

Information in the practice showed us there were clinics for patients with long-term conditions like diabetes and asthma and chronic obstructive pulmonary disease (COPD). The practice nurses, who ran many of these clinics, had undertaken specialist training to ensure they could offer an informed, bespoke service to patients with long term conditions. The nurse told us they talked with patients about self-management of their long term health condition and together developed management plans.

There were appointments for patients offered on a Saturday to patients [CN1] with diabetes by a nurse practitioner. Patients who used these clinics told us how this positively impacted the way they managed their condition. A nurse told us about a patient with diabetes who had not seen a GP for years and did not engage easily with the practice. They attended the weekend clinic and the nurse was able to assist the patient manage their condition safely. The nurse told us the Saturday clinic was very effective in reaching patients who otherwise would not visit the practice.

Information on the practice website informed patients that a GP partner had developed a rheumatology out-patients' service and saw patients once a month at the practice. Nurses attended regular training in relation to the specialist long term condition clinics they offered. This enabled them to provide patients with up-to-date information about their condition and their medications.

The practice manager told us patients with long term conditions were offered double appointments when they were experienced more than one health condition so they were only being called once per year. Patients we spoke to told us they found this useful. Health checks were being delivered by the health care assistants to assist the practice identify sufferers of chronic disease.

There was Information on long term conditions in the waiting room. A GP partner told us the new computer system would allow GPs to print leaflets directly from the patient record. This would assist patients to develop strategies to manage their condition.

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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

Summary of findings

The practice had a variety of clinics to assist mothers, babies and young children. Staff worked closely with the local health visitors and community midwives to identify children who were at risk and ensure they received appropriate care and treatment. Parents we spoke with told us the staff had good communication skills and were good at explaining care and treatment options to younger patients.

Our findings

The practice offered many clinics for pregnant women and mothers and babies as the patient population group had twice the national average birth rate. There were three maternity clinics per week, two clinics were run by one midwife only and a midwife and a GP ran consecutive clinics.

The practice worked closely with local health visitors, midwives and mental health professionals specialising in paediatric care. There were weekly meetings with the health visitor to improve care for children. A member of administrative staff ran a childhood immunisation recall system and liaised closely with health visitors and midwives to follow up any non-attendance (DNAs) in the immunisation clinics to ensure children's safety.

A GP conducted six to eight week checks for babies which were linked to the baby immunisations. Parents we spoke with told us the staff had good communication skills and were good at explaining care and treatment options to younger patients. Parents who had children confirmed all children aged one to five years were seen on the same day. This ensured younger children received a safe timely service.

The practice had a process to ensure the close monitoring of mothers, children and young people and families living in disadvantaged circumstances. There was a health visitor available for easy referral in the building. The GPs in the practice held meetings with the health visitors to discuss patient care and ensure a consistent approach to their treatment.

They had a comprehensive breastfeeding policy where they made the waiting room area accessible to feeding mothers and provided privacy for those who wanted it.

The practice worked with other organisations to try and improve the health and wellbeing of the younger population. Patients were referred to sexual health and mental health programmes and given advice and information about community groups where they could access confidential consultations with trained staff.

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

Summary of findings

Working patients were able to receive advice and support outside traditional working hours. There were early morning appointments and the practice opened until 6.30pm every evening. The practice offered Saturday appointments for patients who had diabetes with the nurse practitioner.

Our findings

Patients who were working were able to access advice and support outside traditional working hours. There were early morning appointments each Wednesday and Friday starting at 7am in the morning. Every week day the practice was open until 6.30pm and the practice offered Saturday appointments for patients with diabetes with the nurse practitioner. There were also flu clinics offered on a Saturday. Friday afternoon appointments were kept back for people who worked as the practice had identified they tended to be more available just before the weekend.

The practice operated an appointment system where appointments were booked on the same day they were requested. A GP partner told us one third of all appointments were pre booked. The other two thirds were available for same day appointments to assist patients see a GP quickly. Working patients could phone the practice before they went to work and be seen by a GP after they finished work.

The practice had identified that the patient participation group (PPG) was not representative of the patient list. They were actively encouraging new membership amongst younger members of working age so they could ensure they had access to their views about how the practice met their needs.

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

Summary of findings

Staff had developed links with the traveller community. They assisted travellers who could not read by carefully describing the medicine regime and the treatment options to ensure they understood them. The practice had a system to ensure patients with a learning disability were identified and received an annual health check.

Our findings

The practice had developed strong links with the traveller community. There were several travellers' sites close to the practice. A GP told us how they assisted travellers who could not read by carefully describing the medicine regime and the treatment options to ensure they understood them.

Patients from the traveller community were routinely offered longer appointments and staff assisted them in the registration process to make it as accessible as possible. Staff members spoke warmly of their relationship with the traveller community.

We saw the practice had a system in place to identify patients with a learning disability and to ensure GPs arranged annual health checks for these patients. Patients with learning disabilities were also offered additional time when speaking with GPs and, if necessary, involve their carer to support with communication.

A practice nurse also worked at a local specialist clinic for sexual health and there was a GP specialist in this area. Patients could be booked in with either staff member for easy access to specialist advice and treatment.

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

Summary of findings

The practice was aware of the high prevalence of depression in its patient population and was proactive about working closely with local mental health services to ensure patients were well supported. Staff were educated and informed about local support services and they provided a range of information to patients. The appointment system enabled patients with poor mental health to be seen quickly.

Our findings

The practice was aware of a high prevalence of depression in its patient population. In 2013 they conducted an audit of patients on anti-psychotic medication to ensure safety and check the accuracy of the register for patients with mental health needs. Staff we spoke with demonstrated a non-judgemental attitude towards patients with mental health needs.

A mental health service which supports people in Oxfordshire suffering from anxiety or depression has space in the surgery to deliver its clinics. The service was part of a programme to make National Institute for Health and Care Excellence (NICE) approved psychological treatments like cognitive behavioural therapy available to people suffering from depression and anxiety. This showed us patients at the practice with mental health needs had access information on, treatment of, and guidance about mental health issues.

The practice appointment system offered an accessible service for patients having varying mental health needs and for those who required flexibility. However, the new address of the drug and alcohol service on a poster in reception had not been updated. Patients who visited the practice and who might want to use the drug and alcohol service were at risk of being sent to the wrong venue.

A GP at the practice was on the clinical commissioning group (CCG) steering panel for mental health services which allowed the practice to provide patients with information about support services in the local area.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered provider did not protect people against the risks associated with the unsafe use and management of medicines as expired medicines were available to be used. Medicines and prescription pads which were completed by hand were not stored securely.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered provider did not protect people against the risks associated with unsafe systems used to assess the risk and spread of infection practice as they did not have appropriate systems to assess the risk of and to prevent, detect and control the spread of infection.