

# The Rycote 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.

## Ratings

Overall rating for this service		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Rycote Practice on 20 July 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- There were nine patients registered with the practice who were diagnosed with a learning disability. All these patients had an annual health check in 2014/15 but only three had the same check in 2015/16.

# Summary of findings

- Two vials of medicine held for emergency use were found to be past their expiry date. These medicines were removed and replaced during the inspection and the practice reinforced their checking procedure.

We saw areas of outstanding practice including:

- The practice had enlisted the support of patients with long term conditions to act as patient teachers for medical students and GPs in training. These patients related their experiences of living with long term conditions to the trainees and students to give them a better understanding of how to treat and care for patients with similar conditions. Other patients with these conditions were able to benefit from the knowledge gained by the students and trainees.
- The practice took a proactive approach to encouraging patients to attend for cancer screening. For example, 97% of eligible patients attended for cervical cytology screening compared to the national average of 82%.

- A visiting counsellor led regular sessions to support the senior leadership team work through the challenges of general practice.

The areas where the provider should make improvements are:

- Ensure patients with a learning disability are supported to access the practice or other services for health checks.
- Ensure reception staff are trained to operate the hearing loop to assist patients who wear a hearing aid.
- Ensure that the practice policy for checking emergency medicines is operated consistently to make sure checks of these medicines are carried out thoroughly

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and generally well managed. However, on the day of inspection we found two medicines held for use in an emergency were past their expiry date. The last check of these medicines had not identified this. The practice removed and replaced the medicines before the inspection was concluded.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- There were nine patients registered with the practice who were diagnosed with a learning disability. Three patients had an annual health check in the previous year.

### Are services caring?

The practice is rated as good for providing caring services. We observed a strong patient centred culture:

Good



# Summary of findings

- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example, delivering prescriptions to patients who found it difficult to get to the pharmacy.
- We found positive examples to demonstrate how patient's choices and preferences were valued and acted on
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Staff assisted patients who found it difficult to book their hospital appointments.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found they could make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



## Are services well-led?

The practice is rated as good for being well-led.

- Governance and performance management arrangements had been proactively reviewed. The practice had lead GPs for specific activities and management functions. The partnership took joint responsibility for managing the service with one of the partners taking a co-ordinating role.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.

Good



# Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance and clinical performance review meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.
- The practice enlisted the support of an external counsellor to support the team by provision of regular sessions at which the team were encouraged to support each other. These included the opportunity to discuss both successes and challenges the practice encountered or faced.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people.

Good



- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The GPs undertook a weekly visit to the local care home where fifty patients lived who were registered with the practice.
- Practice nurses visited older patients in their homes to administer their annual flu immunisations.
- The practice worked closely with a local voluntary group to support older patients to maintain independence.
- The practice had worked with other local organisations to set up a website for carers. The website contained additional information about local support organisations.

### People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. These reviews were scheduled using a recall programme. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Performance for diabetes related indicators was 90% which was comparable to the clinical commissioning group (CCG) average of 94% and national average of 89%. More patients than the national and local averages attended for checks related to their diabetes.
- Every effort was made to reduce the number of review appointments for patients with more than one long term condition. Recall programmes were kept under review to co-ordinate one recall for this group of patients.

# Summary of findings

## Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young patients who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 98%, which was significantly higher than the CCG average of 83% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

Outstanding



## Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Extended hours clinics were held on a Monday evening and Tuesday and Thursday mornings in response to patient feedback.
- Saturday morning extended hours clinics included both pre-bookable and walk in appointments.

Good



## People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including carers and those with a learning disability.
- The practice had identified 28 patients whose social circumstances or complex health needs also made them

Good





# Summary of findings

vulnerable. The patients identified were not included on any other patient register. The medical records for these patients carried an alert to identify them as needing either urgent or longer appointments.

- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- There were nine patients registered with the practice who were diagnosed with a learning disability. Three patients had an annual health check in the previous year.

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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 94% of patients diagnosed with a severe and enduring mental health problem had an agreed care plan in place. This was above the CCG average of 89% and national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice offered a dementia screening programme to identify signs of dementia at an early stage. We saw that 35 patients had attended for screening in the last year and 18 had been identified with early onset of the disease. Early intervention to support these patients had been possible.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



# Summary of findings

- The practice used their mental health and dementia registers to identify patients who may need more flexible access to see the GPs and nurses.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. The last survey was sent to 223 patients and 122 were returned. This represented 0.8% of the practice's patient list.

- 84% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 84% and the national average of 73%.
- 93% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 89% and the national average of 85%.
- 93% of patients described the overall experience of this GP practice as good compared to the CCG average of 90% and the national average of 85%.
- 90% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 83% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 39 comment cards which were all positive about the standard of care received. Patients commented on clinical staff being friendly caring and showing a genuine interest in the wellbeing of the patient and their families. They also commented on being involved in decisions about their care and receiving advice that assisted them in following their treatment plans. Five of the patients who completed comment cards included references to less positive aspects of their experience of the appointment system and waiting times when they arrived for appointments.

We spoke with 13 patients during the inspection. All 13 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Data showed 64 patients had completed the friends and family recommendation test in the last year. Of these 98% would recommend the practice to a member of their family or someone moving into the area.

## Areas for improvement

### Action the service SHOULD take to improve

- Ensure patients with a learning disability are supported to access the practice or other services for health checks.
- Ensure reception staff are trained to operate the hearing loop to assist patients who wear a hearing aid.
- Ensure that the practice policy for checking emergency medicines is operated consistently to make sure checks of these medicines are carried out thoroughly.

## Outstanding practice

- The practice had enlisted the support of patients with long term conditions to act as patient teachers for medical students and GPs in training. These patients related their experiences of living with long term conditions to the trainees and students to give them a better understanding of how to treat and care for patients with similar conditions. Other patients with these conditions were able to benefit from the knowledge gained by the students and trainees.

## Summary of findings

- The practice took a proactive approach to encouraging patients to attend for cancer screening. For example, 97% of eligible patients attended for cervical cytology screening compared to the national average of 82%.
- A visiting counsellor led regular sessions to support the senior leadership team work through the challenges of general practice.

# The Rycote Practice

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a second CQC inspector.

## Background to The Rycote Practice

The Rycote Practice is located in a purpose built health centre that is shared with another GP practice. All consulting and treatment rooms are situated on the ground floor and these have been refurbished and redesigned within the last five years. There are bus routes close by and disabled parking bays are provided close to the practice main entrance. The community hospital is next door to the practice and a range of services such as, podiatry and dietician clinics are available to practice patients at the hospital.

There are eight GPs working at the practice. Six are partners and two are salaried they make up 5.64 whole time GPs. Four are male and four female. The practice nursing team consists of two nurse practitioners, four practice nurses and three health care assistants. All are female and are equivalent to 5.6 whole time nurses. The practice has appointed a third nurse practitioner who is due to start later in 2016. The practice manager is supported in the day-to-day delivery of general management functions by a team of six administration and 10 reception staff. All are part time. There are four contracted locum administration

staff who cover staff absences when required. The practice is accredited to deliver training for qualified doctors who are seeking to become GPs and placements are offered to medical students.

Approximately 11,600 patients are registered at the practice. Over 20% of the patients are aged over 65 years. The practice provided services via General Medical Services (GMS) contract. (A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. National data shows that there is minimal income deprivation amongst the registered population. A significant majority of patients have English as their first language. Most are white British. Translation services are available for those patients whose first language is not English but these services are rarely required.

The practice is open between 8am and 6.30pm Monday to Friday. The duty GP covered 6pm to 6.30pm when the out of hours service took over responsibility. Appointments are offered from 8.20am to 11.30am every morning and 2.20pm to 5.50pm daily. The practice is open from 7.15am on both Tuesday and Thursday morning for extended hours clinics with appointments commencing at 7.30am. Both GP and health care assistant (HCA) appointments are available at these early morning clinics. Extended hours appointments are also offered, by GPs and the nurse practitioner, on a Monday evening between 6.30pm and 7.15pm. The practice offers Saturday morning extended hours between 8.30am and 10.30am when a mixture of on the day and pre-bookable appointments are available.

The practice has opted out of providing out of hours services to their patients. The out of hours service is provided by Buckinghamshire Urgent Care and is accessed

# Detailed findings

by calling NHS 111. Advice on how to access the out of hours service is contained in the practice leaflet, on the patient website and on a recorded message when the practice was closed.

All services are provided from:

The Rycote Practice, Thame Health Centre, East Street, Thame, Oxfordshire, OX9 3JZ

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 July 2016. During our visit we:

- Spoke with four GPs, a GP trainee, three members of the practice nursing team and five members of the administration and reception team
- Also spoke with 13 patients, including three members of the patient participation group

- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed a range of practice policies and procedures relevant to the management of the service.
- Undertook observations and checks of practice facilities and equipment.

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

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

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

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

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

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice recorded an event when action had not been taken to follow up a test result when it first arrived at the practice. Nurses were instructed to allocate test results to a named GP and the duty GP instructed to review all results every day. The new system was designed to ensure prompt review of all test results and ensure none were left without action being taken.

The practice also had a system for processing safety alerts relating to medicines, equipment and premises.

- A member of staff held responsibility to receive, log and distribute safety alerts to relevant members of staff. We saw the log of receipt.
- The safety alert records held showed when action had been completed and who had completed it.
- The lead GP for prescribing received all alerts relating to medicines and had a system in place to ensure action was taken in response to these alerts when they were relevant to practice patients. For example, one alert

related to a medicine that was prescribed for 12 patients registered with the practice. We saw that all 12 patients had been contacted to advise why their medicine needed to be changed.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nursing staff were trained to safeguarding level two and administration staff to level one. All staff had received training in safeguarding of vulnerable adults.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff we spoke with were able to describe the way they conducted their chaperone duties and this met best practice. There was a record of a learning event where chaperone training had been undertaken.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the nurse practitioners was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw

## Are services safe?

evidence that action was taken to address any improvements identified as a result. For example, the box for receipt of specimens had been changed to ensure it was constructed of non-permeable material.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice mostly kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). We undertook checks of vaccines and medicines held at the practice. All of the vaccines were stored appropriately and records of fridge temperature checks showed the vaccines were maintained at appropriate temperatures. The practice held a portable refrigeration unit which they used when taking flu immunisations to patients in their own home. It was also used to hold childhood immunisations during busy clinics. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Two of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. We reviewed 17 of the PGDs and found they were in date and appropriately authorised for use. Travel immunisations were administered against a prescription or written direction from a prescriber. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- The practice held a small stock of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed seven personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of

identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. Records of fire drills were held. We saw action taken arising from a fire drill in 2015 included replacing batteries in automated fire door closers. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. A second supply of emergency medicines was also held in a carry case, in a secure area, which GPs used when undertaking home visits. We checked both



## Are services safe?

sets of emergency medicines. Those in the carry case were in date. However, when we checked the emergency medicines for use within the practice we found two vials of one medicine went out of date at the end of May 2016 and three syringes were also out of date since January. There was a risk that these medicines could have been administered to a patient when they were expired and not fit for purpose. The medicines were removed from the emergency medicine box immediately. There was a record of the emergency medicines being checked every month. It was evident that the last check had not identified these two vials were nearly two months past their expiry date. They

were replaced before we concluded our inspection. The practice also raised a significant event, as a result of our findings, regarding their processes for checking medicines held were in date and fit for use.

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. We were given an example of when the plan was put into action when the ground floor staff room suffered water ingress from a broken tap on the first floor.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available. Exceptions from the indicators were mostly below average. Where they were above average, for example in some indicators for patients with mental health problems, we reviewed the rationale for the exception. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). We found that exceptions could only be authorised by a GP. On close scrutiny the exceptions were found to be clinically justified. For example, in some cases a patient had a diagnoses made some years previously and had not presented with similar symptoms for some years. The GPs were in the process of reviewing these patients to confirm or remove the initial diagnosis. We also noted, from practice data for 2015/16 that exception rates had reduced from the previous year. The data supplied by the practice for 2015/16 showed 100% achievement of the overall QOF indicators. This performance could not be compared with other practices because the comparative data had not been published at the time of inspection and reporting.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was 90% which was similar to the clinical commissioning group (CCG) average of 94% and national average of 89%. However the practice exception reporting rates for diabetes indicators were consistently lower than both CCG and national averages.
- Performance for mental health related indicators was 100%. This was above the CCG average of 95% and national average of 93%. However, the exception reporting rate for these indicators was higher than both the CCG and national averages. For example, the exception reporting rate for having an agreed care plan in place for patients with a severe and enduring mental health problem was 20%. This compared to the lower average rates of 12% for the CCG and 13% nationally.
- 82% of patients diagnosed as living with dementia had their care reviewed at a face to face consultation compared to the CCG average of 85% and national average of 84%. The exception reporting rate for this indicator was 7% compared to the CCG average of 6% and national average of 8%.
- 92% of patients diagnosed with COPD (a type of lung disease) had an assessment of their breathlessness compared to the CCG average of 91% and national average of 90%. However the exception reporting rate for this indicator was 5% compared to the CCG 14% and national 11%.

There was evidence of quality improvement including clinical audit.

- There had been 21 clinical audits completed in the last year. Of these, four were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, the practice had conducted two audit cycles of an audit arising from recent research to reduce the risk of prostate cancer going undetected in male patients aged under 60 years old. The audit looked at the results of blood tests that could indicate a higher risk of prostate (a gland in the male reproductive system) cancer in men under 60 years of age. The first audit identified 30 patients under 60 years of age having the test. Where a slightly elevated result was found in 21(70%) of the patients they were placed on a recall programme to repeat the test in one year. This was

# Are services effective?

## (for example, treatment is effective)

because the slightly elevated result could place the patient at risk at a later stage. The GP who undertook the audit advised colleagues of the audit and the follow up programme when a slightly elevated result was found. They also ensured the 21 patients were included in the recall programme for a second test. The audit was repeated two years later in 2016. This identified 36 patients with the raised level from the test. Of these 18 (50%) were identified with the slightly elevated result and required to be placed on the recall programme or the reason for the elevated level investigated. These patients were called for early follow up by their usual GP. Further education in responding to this test was undertaken and the audit scheduled for repeat. The audits showed the practice was responding to current research with a focus on reducing the risk of male patients under 60 years of age developing prostate cancer at a later stage.

Information about patients' outcomes was used to make improvements. For example the practice identified that patients receiving leg ulcer treatments or wound dressings were not being given sufficient time for these treatments in the nurse clinics. The practice took action by ensuring nursing staff received refresher training, from a tissue viability nurse, in these treatments and adjusting the nurse appointment timings to allow sufficient time to complete the treatments..

The practice had a system to monitor urgent referrals. Records were kept of patients referred with suspected cancer requiring an appointment within two weeks. If the patient had not been seen within the two weeks the referring GP contacted both the hospital department and the patient to follow up the referral.

### Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Nursing staff attended annual updates for the long term conditions they held responsibility for.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

# Are services effective?

## (for example, treatment is effective)

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young patients, staff carried out assessments of capacity to consent in line with relevant guidance. The nursing staff we spoke with were very clear in their understanding of this legal framework. This included how they would report any safeguarding concerns they encountered when treating young patients who were able to give their consent to treatment.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- Smoking cessation advice was available from practice nursing staff. Data showed that 16 patients had attended a formal smoking cessation programme in the last year. The practice had identified 13% (1249) of registered patients over the age of 16 as smokers. Advice on the benefits of stopping smoking was given opportunistically or by contacting the patient. The practice had given such advice to 99% of those identified. Data showed that 266 patients had stopped smoking since being offered cessation advice.
- GPs were able to refer patients to both exercise and weight management programmes held locally.
- The practice took an active role in the Thame show offering patients and the public the opportunity to discuss healthy lifestyle plans

The practice's uptake for the cervical screening programme was 98%, which was significantly above the CCG average of 83% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening

programme and the practice followed up women who were referred as a result of abnormal results. The practice was aware that their exception rate from the cervical screening programme, in 2014/15, had been higher than average. They had introduced a third reminder to encourage attendance and this had reduced the exception rate. Data showed that 96 out of 231 patients who had not responded to their initial invitations subsequently attended.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The number of eligible female patients attending for breast screening in the last three years was 82%. This compared favourably to the CCG average of 75% and national average of 72%. Attendance for bowel screening in the last 30 months was 66%. This again was above the CCG average of 59% and national average of 58%.

We were unable to access comparative national data for childhood immunisation rates. The practice provided data that showed the average rate for the vaccinations given to under two year olds was 98%. The CCG average range for these vaccinations was 90% to 97%. The practice data showed an average administration rate for vaccinations of five year olds of 93%. The CCG averages ranged from 92% to 98%.

The practice offered early dementia screening to patients who may be at risk. In the last year 41 patients had been invited for screening and 35 attended. The practice recorded that the remaining six patients declined screening. This screening identified 18 patients with early onset of dementia and this meant advice and support could be offered at an early stage in the illness.

There were nine patients diagnosed with a learning disability. These patients were on a learning disability register. It was recognised that completing an annual health check-up for this group of patients often identified other health problems. Early intervention could then be initiated. We noted that the practice had completed reviews for all nine patients in 2014/15; however the practice had completed only three annual health reviews for the nine patients in 2015/16. The practice sent us a copy of a recall protocol, written within 24 hours of inspection. The protocol aimed to ensure all these patients were encouraged to attend for their health check in 2016. It included an easy read format letter for the patient.

## Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

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

All of the 39 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 94% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.

- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 91% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

We were given examples of GPs and nurses ensuring patients received personalised care. These included; GPs delivering prescriptions to patients who found it difficult to get to the pharmacy and visiting patients who had not requested a home visit to follow up appointments they had attended at the practice.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 93% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.

However,

- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.



## Are services caring?

We discussed the feedback from the national survey with the nursing staff. They were aware of the feedback and had discussed the findings at one of their nurse team meetings. They told us that they had reflected on their consulting techniques to give more opportunity for patients to become empowered to reach decisions about their care and treatment.

We also looked at the comments patients had posted about the practice, in 2016, on the NHS choices website. We noted that six out of seven postings on this site gave the practice five stars (the top rating). The practice had responded to the one negative comment and had offered the patient a meeting to discuss their concerns.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. We also noted that use of the translation service was encouraged for patients whose first language was not English. The practice policy was to, wherever possible, use independent translators rather than family members or friends.
- Information leaflets were available in easy read format.
- Information leaflets relating to specific medical conditions were available to support the information GPs and nurses had verbally given to patients during their consultation.

### **Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

Two members of staff were responsible for processing referrals to hospital on behalf of the GPs. We were given examples, by one of these staff, of assisting patients to book their appointments when the patient found the booking system difficult to negotiate. They also gave us examples of alerting a local voluntary organisation on behalf of patients that needed a volunteer driver to take them to hospital appointments.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 376 patients as carers (3.3% of the practice list). A member of staff was responsible for alerting local agencies when a patient first registered as a carer. This enabled the patient to receive advice on the support and benefits available to them in their caring role. Written information was available to direct carers to the various avenues of support available to them. One of the members of the patient participation group (PPG) was also a carer and the PPG were actively involved in assisting the practice to support carers in the community. For example, they were in advanced stages of discussion with the practice to establish a Thame carers support group. The practice had worked with other local organisations to set up a website for carers. The website contained additional information about local support organisations.

Staff told us that if families had suffered bereavement their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The records of the deceased patient were checked and if they were due to be seen by another service that service was contacted. This avoided appointment letters being sent to the bereaved relatives.

The PPG had produced a draft of a leaflet advising patients of the support available when receiving end of life care. The draft had been shared with the practice and was due for release in the near future.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example it took an active part in the prescribing management programme to ensure effective prescribing. Data showed the practice in the top 10% of prescribers in the local medicines management programme.

- The practice offered extended hours clinics on a Monday evening until 7.30pm, on Tuesday and Thursday mornings from 7.30am and on Saturday morning between 8.30am and 10.30am. These were particularly useful for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. They were also available for patients identified as vulnerable. Home visits were carried out by the patient's usual GP to facilitate continuity of care.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available. However, staff identified a need for refresher training on how the hearing loop was operated.
- All consulting and treatment rooms were located on the ground floor.

### Access to the service

The practice opened between 8am and 6.30pm Monday to Friday. Appointments were offered from 8.20am to 11.30am every morning and 2.20pm to 5.50pm daily. The practice opened early from 7.15am on both Tuesday and Thursday mornings for extended hours clinics with appointments commencing at 7.30am. Both GP and health care assistant (HCA) appointments were available at these early morning clinics. Extended hours appointments were also offered, by

GPs and the nurse practitioner, on a Monday evening between 6.30pm and 7.15pm. The practice offered Saturday morning extended hours between 8.30am and 10.30am when a mixture of on the day and pre-bookable appointments were available. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 79% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 84% of patients said they could get through easily to the practice by phone compared to the CCG average of 84% and the national average of 73%.

The practice, in conjunction with the PPG, had conducted patient surveys on an annual basis. The results of one of these surveys showed patients would prefer the extended hours evening clinic to be held on a Monday. Evening clinics were therefore put in place for Monday evenings.

The practice had also responded to feedback in regard to availability of pre-bookable appointments. The opportunity to obtain appointments two days in advance had been added to the appointment schedules. However, we received five comments from patients, via discussions and comment cards, reporting delays in obtaining appointments with their usual GP. We noted that these comments were made at a time when GPs were preparing to commence annual leave.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Requests for home visits were recorded and allocated to the patient's usual GP. The GP assessed the urgency for the visit. This was done by checking the patient's records, from their personal knowledge of the patient or by calling the patient. If the patient's usual GP was not available the duty GP was allocated the visit and called the patient to assess



# Are services responsive to people's needs?

(for example, to feedback?)

the clinical need. In rare cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

## Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. It was displayed in the waiting room, detailed in the patient leaflet and on the practice website. Staff we spoke with told us how they would support a patient who wished to make a complaint.

We looked at 14 complaints received in the last 12 months and found all had resulted in a thorough investigation. This was followed by a prompt and detailed response to the patient. We reviewed a random sample of three of the complaints in detail. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a patient had raised a complaint relating to receiving a diagnosis during a Saturday morning appointment. The patient asked to change their usual GP. After discussion with the patient they withdrew their request to change GP. The practice reflected that face-to-face discussions with a patient lodging a complaint assists in resolution and ensures the patient receives all information found from investigating the complaint. The practice also discussed trends in complaints with the PPG and the PPG fed back any issues they had been made aware of from their contact with other registered patients. This enable the practice to address any issues of concern raised by patients informally. For example, recent feedback had been received regarding a local pharmacy misplacing prescriptions. The practice had commenced discussions with the pharmacy.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was underpinned by their mission statement to deliver excellent care by working as a team.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented, kept up to date, and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. Nursing staff gave us examples of the prompt support they received from GPs if they needed advice on treatments or had a concern about a patient's condition.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team learning events were held every month and involved the whole team.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice enlisted the support of an external counsellor to lead regular group therapy sessions for the senior leadership team. This enabled the team to discuss the challenges faced in general practice.

### Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice

# Are services well-led?

Good 

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

management team. For example, the last survey had identified concerns relating to conversations with reception staff being overheard. The practice responded by moving the waiting room away from reception during the refurbishment and introducing a system requesting patients to stand back from reception whilst others spoke with reception staff.

- The practice had gathered feedback from staff through protected learning events, and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. For example, when the building refurbishment took place the administration office was moved from the back of reception to one side. This responded to staff's feedback that telephone discussions could be overheard by patients when the office was in its original location.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice

team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had a programme called 'patients as teachers'. This involved patients with long term conditions attending the practice to educate GPs in training, and medical students, on the difficulties they faced and their expectations for their follow up and consultation for their conditions. The programme gave aspiring GPs and medical students an insight into caring for this group of patients.

The practice was active in co-ordinating follow up care for patients with more than one long term condition. They demonstrated that they were reducing the need for multiple appointments for this group of patients. The work was ongoing to offer the coordinated reviews to as many patients as possible.

There was evidence of the practice working with community groups in the planning of services in the area.

The practice had appointed a third nurse practitioner to expand the range of services and appointments available to patients.