

Oak Tree Partnership

Quality Report

Oak Tree Health Centre
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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?		Requires improvement	
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 of Oak Tree Partnership at Oak Tree Health Centre on 8 September 2015.

This was the first inspection using the CQC comprehensive inspection programme. Overall the practice is rated as good. We found the practice good for the delivery of safe, caring, responsive and well led services. They were also good for delivery of services to the population groups of working age people (including those recently retired and students), families children and young people and people whose circumstances may make them vulnerable. However, the practice was found to require improvement in delivering effective services and for the care of people with long term conditions and people experiencing poor mental health (including those with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to annual checks for patients with long term conditions.
- Data showed patient outcomes were below average for the locality. Although some audits had been carried out, we saw limited evidence that audits were driving improvement in performance to improve patient outcomes.
- 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.
- The majority of appointments were available on the day the patient called the practice. The practice operated a system whereby GPs contacted all patients

Summary of findings

requesting an appointment on the day of their incoming phone call. Appointments were then undertaken by phone or by calling the patient in for a same day face to face consultation.

- The practice had a wide range of policies and procedures to govern activity. These were all reviewed on a regular basis and staff knew how to access these to support their day to day duties.
- Staff were appropriately trained to carry out their duties and received support through appraisals and supervision.
- The practice had a vision and strategy underpinned by a business plan which recognised challenges and opportunities in the future.
- 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.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure performance in undertaking annual checks and reviews for patients with long term conditions is improved and the outcomes of the checks appropriately and accurately recorded.
- Ensure the care and treatment of patients experiencing poor mental health follows national guidelines and is accurately and appropriately recorded.
- Improve the identification of the smoking status of patients and increase the advice given on the benefits of stopping smoking. Data showed the practice was achieving much lower rates of identification and advice compared to the CCG average.

In addition the provider should:

- Ensure cleaning standards are effectively monitored to achieve consistent appropriate standards of general cleanliness in all clinical rooms.
- Continue to improve the patient experience from the survey feedback improvement plan.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

Good



Are services effective?

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were low compared to the CCG averages. There was limited evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. However, multidisciplinary working was taking place and was working well. The current team of GPs and nurses had knowledge of and referenced national guidelines.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services. Data showed that patient feedback in relation to being treated with care and compassion was improving. There was recent evidence of patients reporting that they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Recent surveys, and patients we spoke with, confirmed patients found it easy to make an appointment. Patients received a consultation on the day they contacted the practice, either by phone or at the practice. Appointments with the nurses could be booked in advance.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. The strategy was embodied in a business plan that identified the need to improve performance in QOF and clinical audit. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings. However, evidence of completed clinical audit cycles was limited.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for the care of older people. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed. For example 100% of targets for treating patients with heart failure were achieved whilst only 41% of targets for patients with lung disease were met.

Longer appointments and home visits were available for older people when needed. There were less than 700 patients registered over the age of 65. The practice had recognised the need to improve services to this age group and had commenced work, identified in the practice business plan, on doing so.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the care of people with long-term conditions. Nursing staff and GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. However, data showed the practice was either not undertaking or had missed recording a number of reviews for patients with long term conditions. The practice performance for achieving review targets was 15% below the national average for many disease areas but we saw this had improved since 2014. The business plan identified the need to improve and work had started with a new team of GPs and nurses in place. Longer appointments and home visits were available when needed.

Requires improvement



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. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. There were examples of joint working with midwives and health visitors.

Good



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

Good



Summary of findings

working age population, those recently retired and students had been identified. The practice was actively engaged in clarifying access to appointments for this patient group. Telephone consultations were available throughout the opening hours of the practice and patients were able to state their preferred time to be called.

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. However, smoking cessation advice rates were low compared to other practices.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Only just over 50% of people experiencing poor mental health had received an annual physical health check. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health. Appointments with the patient's preferred GP were available on the day the patient called seeking advice or support. The practice had access to counsellors on site.

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

Requires improvement



Summary of findings

What people who use the service say

The views of patients were sought by the practice by various means. Patient surveys had been conducted up to 2014 and the practice actively encouraged patients to take part in the friends and family survey and reviewed the responses. There was also a small patient participation group backed up by a wider patient representative group of 210 patients. We saw that the practice had responded to patient feedback by increasing the number of practice nurses from two to three. They had also recruited a permanent team of GPs and made some book in advance appointments available with the health care assistants. The evidence from these sources showed patients were satisfied with the care and treatment they received.

However, the national GP survey had been undertaken between July and September 2014 and January to March 2015. The survey was completed by 109 patients which was a 36% response rate against the 301 survey forms sent out. At that time the practice was in the process of recruiting a GP partner, a salaried GP and two practice nurses. The results were not as positive as other practices received. For example:

- 77% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.

- 94% said the nurse was good at listening to them compared to the CCG average of 93% and the national average of 91%.
- 82% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 88% patients said they could get through easily to the surgery by phone compared to the CCG average of 83% and national average of 74%.

We spoke with eight patients on the day of inspection and reviewed 19 CQC patient comment cards. Ninety three per cent of the comments we received, in person and from the comment cards, were positive about the care and treatment received and with access to appointments.

We saw the practice kept appointment availability under review and that they continued to clarify the appointment system to assist patients in their understanding of how to access an appointment. The practice had a programme of annual surveys. When a patient posted a comment on NHS choices the practice responded. .

Areas for improvement

Action the service MUST take to improve

- Ensure performance in undertaking annual checks and reviews for patients with long term conditions is improved and the outcomes of the checks appropriately and accurately recorded.
- Ensure the care and treatment of patients experiencing poor mental health follows national guidelines and is accurately and appropriately recorded.

- Improve the identification of the smoking status of patients and increase the advice given on the benefits of stopping smoking. Data showed the practice was achieving much lower rates of identification and advice compared to the CCG average.

Action the service SHOULD take to improve

- Ensure cleaning standards are effectively monitored to achieve consistent appropriate standards of general cleanliness in all clinical rooms.
- Continue to improve the patient experience from the survey feedback improvement plan.

Oak Tree Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP advisor and an expert by experience.

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

A member of the CQC data team accompanied the inspectors in the role of observer.

Background to Oak Tree Partnership

The Oak Tree partnership is located in a purpose built health centre which they have occupied since 2002. The practice is in an area of modern housing and there are a larger number of patients aged between 0 and 14 and 25 to 49 years than the average for Oxfordshire and England. There are approximately 700 patients aged over 65 registered with the practice which is significantly lower than the national average. A total of approximately 9,500 patients are registered and the practice has experienced a steady growth in registered patients of around 4% per year in the last five years. We had visited the practice in February 2014 using the CQC inspection methodology and regulations in force at that time. We found the practice needed to make improvements to cleaning standards and reduce the risk of cross infection. In May 2014 the practice had completed actions to address these issues and were meeting relevant regulations. The practice had undergone

a period of significant change and instability in the last three years following the departure of previous partners. For most of 2014 there were only two GP partners and locum GPs were employed to cover partner vacancies. A number of staff had left the practice at a time when the practice continued to increase its registered patient population. Delivering a service that offered continuity of care for patients had proven difficult during that time. In 2014 the practice successfully recruited an additional salaried GP and a new partner, and the existing two salaried GPs opted to become partners. The continued population increase in Didcot coupled with the resource issues the practice faces pose a significant challenge.

Six GPs work at the practice equating to just over 4.5 whole time GPs. Five are partners and one is an employed GP. Four of the GPs are female and two male. Two of the GPs hold additional diplomas in obstetrics and gynaecology. There are three practice nurses, one is full time and the other two work just over half the week each. One of the nurses is a qualified prescriber. There are two health care assistants. The practice currently holds a Personal Medical Services (PMS) contract which it had negotiated locally. It is moving to a General Medical Services (GMS) contract in January 2016. GMS contracts are nationally negotiated by GP practices with NHS England.

The practice is open between 8:20am and 6.30pm hours Monday to Friday. It operates a system called GP access where patients receive a call from a GP to either assess the requirement for a face to face appointment or complete the appointment over the phone. Data shows 60% of appointments are completed as telephone consultations. The majority of face-to-face appointments are offered on the day the patient calls and can be given at any time from 9am until the practice closes. When the GP assesses a routine appointment is required this can be offered up to

Detailed findings

four weeks in advance. Appointments with practice nurses and health care assistants can be booked directly through reception. These appointments can be booked in advance, and some limited appointments can be booked online.

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by Oxfordshire GP out of hours service. The service is accessed via NHS 111. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice and on the patient website.

CQC carried out an inspection under previous inspection arrangements and superseded regulations in November 2013. At that time we found the practice had breached one of the regulations in force. The practice took action and we carried out a follow up exercise in May 2014 when we found the practice had addressed the issues that breached the regulation.

All services are provided from:

Oak Tree Health Centre, Tyne Avenue, Didcot, Oxfordshire, OX11 7GD

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had been inspected before under an earlier inspection methodology and against regulations that have been superseded. On first inspection in February 2014 we found a breach of regulation. The provider took action to rectify the matters giving rise to the breach and in May 2014 we judged the provider was complying with the regulations in force at that time. Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Prior to the inspection we contacted the Oxfordshire Clinical Commissioning Group (CCG) (a clinical commissioning group is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services), NHS England area team and local Healthwatch to seek their feedback about the service provided by Oak Tree Partnership. We also spent time reviewing information that we hold about this practice including data provided by the practice in advance of the inspection.

The inspection team carried out an announced visit on 8 September 2015. We spoke with eight patients, three GPs and five members of staff. We reviewed 19 CQC comment cards that had been completed in the two weeks prior to our inspection. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

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

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

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

Detailed findings

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

The practice was in an area of low economic deprivation and had a significantly younger population than the

Oxfordshire average. The estimated levels of long term conditions such as hypertension, cardiovascular disease and respiratory diseases reflected the younger age group of patients registered with the practice.

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were recorded and a similar system to significant event reporting was used to deal with these. The minutes from three meetings where significant events were reviewed showed the practice often reviewed complaints and recorded the learning similarly. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, when a young patient was administered with the wrong vaccine the staff checked that there would be no adverse effects with the vaccine supplier and the option to administer the vaccine to young patients was removed from the practice computer system.

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

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- The practice did not display a notice advising patients that a chaperone service was available. However, a patient we spoke with told us they had been offered the service of a chaperone. We discussed this with the practice manager and registered manager and they agreed that the availability of chaperones needed to be promoted. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available on the practice intranet and a poster in the administration office. The practice had up to date fire risk assessments and annual fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed in most areas. We observed the premises to be clean and tidy. The practice manager was the infection control clinical lead and they were able to liaise 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 training relevant to their role. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice had a risk assessment in place for clinical rooms that had not been hard floored and we saw that the main treatment rooms were appropriately designed and maintained.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Practice nurses used Patient Group Directions (PGDs) to administer a range of medicines (PGDs are written instructions for the supply or administration of

Are services safe?

medicines to groups of patients who may not be individually identified before presentation for treatment). We reviewed the PGDs and all were in date. The nurses had been appropriately trained to administer the medicines and vaccines included in the PGDs.

- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty to keep patients safe.

Arrangements to deal with emergencies and major incidents

There was a system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

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 to use if the plan had to be put into action. Staff gave us an example of using the procedure when they found one of the rooms flooded when they arrived to start work.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a voluntary system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 77% of the total number of points available and this showed a nine percentage point improvement on the previous year.

The GPs and management were very aware of the need to improve QOF performance and there were plans in place to do so. We noted that the practice had been through a period of unstable staffing when locum GPs were employed. This had resulted in patient reviews being undertaken and not being properly recorded. Data showed the practice had an exception rate of 3.7 (an exception rate is when a patient with a specific condition is removed from the group of patients requiring follow up and review). This was 6.2 points lower than the CCG average of 9.9. This meant the practice ensured more patients requiring follow up remained on the recall register and were not excluded from the targets. We also noted that the practice had increased the number of practice nurses and recruited a GP partner and salaried GP. This meant both GPs and nurses were committed to the improvements committed to in the practice business plan. All clinical staff were encouraged to attend clinical meetings where clinical performance was discussed and action plans were set. Locum GPs had not been employed since April 2015. We noted that GPs were focused on further improvement in supporting patients

with long term conditions. For example, patients with severe mental health problems had a named GP who was responsible for undertaking the reviews of both their physical and mental health needs.

This practice was an outlier in 2013/14 for some of the QOF clinical targets. Data showed;

- Performance for diabetes related indicators was 71% compared to the CCG average of 94% and national average of 89%.
- Performance for mental health related hypertension indicators was 66% compared to the CCG average of 80% and national average of 82%.
- Performance in carrying out tests for patients with severe mental health problems was between 41% and 76% compared to the national averages of 79% to 88%.
- 65% of patients with hypertension had a blood pressure reading in the target range compared to the CCG and national average of 81%.

However,

- The dementia diagnosis rate was comparable to the CCG and national average.

We noted that the practice included monitoring of QOF in clinical meetings and had an action plan to improve performance in 2015/16. Improvement in recording of clinical reviews and ensuring the reviews took place was one of the top priorities within the practice business plan and we saw the practice had made progress from 2014.

We saw four clinical audits carried out in the last two years, two of these were completed audits where the improvements made were implemented and monitored. The practice did not have an audit plan and we could not evidence that clinical audit was being used to drive improvement in patient care.

The practice had reviewed the implementation of their GP Access appointment system. This showed a 20% reduction in emergency department attendances by improving access to a GP. The practice confirmed this by comparing emergency department attendances during the six months before GP Access was introduced and the six months following.

Are services effective?

(for example, treatment is effective)

The practice undertook a range of monitoring checks at varying intervals to ensure patients were receiving appropriate care and treatment. For example, every month they ran a check to follow up high risk patients who had not attended for their NHS health check which prompted a recall for those who had failed to attend. They also ran a monthly check to identify patients at risk of developing kidney disease and used this to invite patients in for review. The practice participated in applicable local audits and peer review with the CCG.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during one-to-one meetings, appraisals, clinical supervision and facilitation and support for the revalidation of doctors. All staff had received an appraisal within the last 12 months and we saw evidence that all GPs had dates set for their next revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

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 extensive intranet system. This included care and risk assessments, care plans, medical records and test results. The GP advisor reviewed the electronic folder containing test results and other correspondence that the

practice had received and found these had been dealt with promptly. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a six weekly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and increased exercise. Patients were then signposted to the relevant service. Smoking cessation advice was available. However, data showed the practice had given smoking cessation advice to 47% of smokers compared to the national average of 94%. A sexual health clinic, commissioned by the CCG, was held at the practice twice a week. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme in 2014/15 was 82%, which was better than the national average of 77%. There was a policy to offer telephone

Are services effective?

(for example, treatment is effective)

reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 99% and five year olds from 95% to 98%. Flu vaccination rates for the over 65s were 77%, and at risk groups 60%. These were also above CCG and national averages.

Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where risk factors were identified. We noted that the life expectancy of patients living on a housing development served by the practice was one of the highest in England.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to the side of the main reception to discuss their needs.

Eighteen of the nineteen patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered a caring and helpful service and staff treated them with dignity and respect. We also spoke with two members of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded when patient's needed help and provided support when required. We were given examples of when staff had taken patients home when they were finding difficulty in obtaining a lift or getting public transport and of staff delivering prescriptions to patients who were unable to get to the practice.

The national GP survey had been undertaken between July and September 2014 and January to March 2015. At that time the practice was in the process of recruiting a GP partner, a salaried GP and two new practice nurses. The results of the survey reflected the lack of continuity of care arising from locum GPs being employed at that time and a shortage of practice nurses. Consequently, the results were not as positive as other practices received. The survey was completed by 109 patients which was a 36% response rate against the 301 survey forms sent out. For example:

- 77% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.

- 94% said the nurse was good at listening to them compared to the CCG average of 93% and the national average of 91%.
- 82% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 88% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 76% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 98% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.
- 82% patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

We looked at the results of the friends and family survey from January to April 2015, this asks patients whether they would recommend the practice to others. It showed 87% of patients would be likely or extremely likely to recommend the service to others. We also noted that in response to the practice patient survey from 2014 the practice had increased the number of practice nurses from two to three and recruited permanent GPs to enhance continuity of care and availability of appointments. As these appointments had been made since the last national patient survey it was too early to assess the impact on patient satisfaction. We found the GPs we spoke with were committed to the ethos of the practice to help patients stay well. We also noted that reception and administration staff had completed customer care training between January and June 2015. The practice business plan for 2015 incorporated a statement to improve engagement with patient groups to determine what they need in the future.

Care planning and involvement in decisions about care and treatment

Patients we spoke with, and the majority of patients who completed CQC comment cards, told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They

Are services caring?

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.

The results of the last national patient survey were not as positive as other practices received. For example:

- 77% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 85%.
- 88% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

The permanent appointment of GPs and additional nursing staff with a commitment to the practice and the practice business plan was aimed at addressing the issues identified by patients. These staff came into post in late 2014 and early 2015 and it was too early to evaluate whether they had made a difference to the patient views on this aspect of the service. We found the patients we spoke with and comment cards received were positive about involvement in care and treatment.

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.

Patient/carer support to cope emotionally with care and treatment

The practice information screen included access information for a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers. Due to the age group of registered patients there were very few carers identified. Written information was available for carers to ensure they understood the various avenues of support available to them.

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 or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice hosted a sexual health clinic which served the patients of all Didcot practices and the surrounding area. One of the GPs was also active in working with the CCG to plan services for the future as Didcot's population grew.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice had a lift to enable easy access to first floor consulting and treatment rooms.
- The practice used the electronic prescribing service to enable patients to collect their prescriptions from their preferred pharmacy without having to visit the practice.
- The practice registered patients who were homeless.
- Patients experiencing poor mental health were able to access same day appointments with the GP of their choice.

Access to the service

The practice was open between 8:20am and 6.30pm Monday to Friday. Telephone appointments were available throughout the day because the practice offered same day assessment by GPs for all patients seeking advice or treatment. Face to face appointments were available from 9:30am to 6pm. The appointment system enabled all appointments to be accessed on the day the patient called the practice. A limited number of appointments with the health care assistants could be booked up to four weeks in advance.

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 for most of the questions asked but was lower when asked about their experience of making an appointment. For example:

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 88% patients said they could get through easily to the surgery by phone compared to the CCG average of 83% and national average of 74%.
- 84% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.

However,

- 54% patients described their experience of making an appointment as good compared to the CCG average of 80% and national average of 74%.

The practice promoted the availability of a call back at a time to suit the patient and we were given examples of telephone consultations taking place within half an hour of the patient contacting the practice. As a result of the survey undertaken by the practice some appointments with the health care assistant had been converted to book in advance appointments. The practice had also appointed an additional practice nurse to increase the number of appointments available.

The experiences reported in the national survey differed from the experience reported by the eight patients we spoke with and the 19 that completed CQC comment cards. Of these 25 out of 27 were positive about the access they had to appointments and many were complimentary of the on the day appointment system. We saw that if the GPs or nurses were unable to speak to a patient at the first attempt they continued to call until they spoke with the patient. We noted that all patients requesting a call from the GPs and nurses received a call and that every effort was made to ensure advice and treatment was given on the day the patient made first contact.

The practice reflected on the results of the national survey. They conducted their own patient survey of 210 patients. The results from this survey were more positive in regard to appointment access. We saw the practice kept appointment availability under review and that they continued to clarify the appointment system to assist patients in their understanding of how to access an

Are services responsive to people's needs?

(for example, to feedback?)

appointment. The practice had a programme of annual surveys. When a patient posted a comment on NHS choices the practice responded. The practice had collated the results of the friends and family test. This showed over 80% of patients would recommend the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Information was available in the waiting room and on the practice website. The majority of patients we spoke with and who completed

comment cards had not had any cause to complain. The two patients who referred to making complaints in the past reported that their complaints had been handled promptly and were resolved.

We looked at the complaints log for the last 12 months and reviewed all 17 complaints in detail. All were satisfactorily handled and dealt with in a timely way and we saw that investigations had been undertaken before a full reply was given to the patient.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, when a patient was not advised of the number of appointments they needed for their travel vaccinations the system was reinforced to ensure consistent information was given on this matter.

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. Their stated mission was to help patients to stay well and focus on supporting patients to live a healthy lifestyle. There was a practice business plan, which was updated annually, and this showed us that the practice recognised the challenges it faced in the future. The plan also set out the practice commitment to their patients and to continually improve and expand the services offered. The practice business plan had been reviewed in August 2015 and incorporated eight objectives. These included improving QOF performance to improve health outcomes, improving performance in enhanced services to improve health outcomes and to enhance engagement with patients to determine what they will need in the future. It also recognised the challenges the practice would face as patient numbers increased and that developing staff and succession planning were vital to the future.

Staff we spoke with demonstrated their commitment to the objectives. For example, staff were committed to ensuring patients with long term conditions responded to recalls and attended for their annual health reviews. We noted that an additional nurse had been recruited to increase the opportunity for patients to be seen for their long term condition health checks.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- There was an understanding of the performance of the practice and the challenges and opportunities it faced.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice recognised their performance in supporting patients with long term conditions and those experiencing poor mental health required improvement. Plans were in place to address this.

- Clinical Audits were limited and the practice did not have an audit plan.
- The practice engaged with the CCG and was active in planning and delivering services in the local area. For example, the sexual health clinic was held at the practice and was available to all patients in the Didcot area.

Leadership, openness and transparency

The partners in the practice prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, by the partners and their manager. Minutes of significant event reviews showed us that the partners supported staff when they reported concerns regarding dealing with difficult patients. 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.

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

The practice encouraged feedback from patients. It gained feedback from a small PPG and a wider reference group of 210 patients who were contacted by e-mail. We saw that patient surveys had been undertaken on an annual basis up to 2014. The responses from the surveys had resulted in the practice recruiting an additional practice nurse and improving continuity of care by recruiting a GP partner and a salaried GP to reduce reliance on locum GPs. The PPG met on a regular basis. However, the practice did not demonstrate they had responded to the results of the last national patient survey.

The practice had also gathered feedback from staff through staff briefings, appraisals and day to day discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example a member of staff identified that prescriptions had been sent to the wrong pharmacy.

Are services well-led?

Good 

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

Management addressed the issue and implemented a control system to reduce the risk of this happening again. Staff told us they felt involved and engaged to improve how the practice was run.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Family planning services	Regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Maternity and midwifery services	Safe care and treatment
Surgical procedures	12.—(1) Care and treatment must be provided in a safe way for service users.
Treatment of disease, disorder or injury	(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; <ul style="list-style-type: none">• The risks of not carrying out annual health reviews for patients with long term conditions had not been appropriately assessed.• The provider had not robustly identified the reasons for below average QOF performance or taken prompt action to ensure patients with long term conditions were safely and appropriately cared for.• The identification of smokers and offer of smoking cessation advice was low compared to other practices in the CCG.