

# Windrush Medical Practice, Windrush Health Centre

## Quality Report

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Date of inspection visit: 5 May 2016  
Date of publication: 17/06/2016

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

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

# 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 Windrush Medical Practice on 5 May 2016. Overall the practice is rated as outstanding. Specifically it is rated outstanding for the provision of safe, effective and well led services and good for the provision of caring and responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, using e-mails and photographs to communicate with specialists at the local hospital to reduce the need for patients to travel to outpatient clinics.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example by providing a floor within the practice for visiting services such as audiology and orthopaedic clinics. They also hosted the 'hub' which provided an overflow facility for urgent GP and nurse appointments when practices in West Oxfordshire had filled their appointments.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example a new telephone system had been installed and staff rosters amended to make more staff available to answer patient calls at peak times.
- The practice had modern and well maintained facilities and was well equipped to treat patients and meet their needs.

# Summary of findings

- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as top priorities. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.
- An innovative approach to training qualified doctors. This involved running a simulated clinic with case studies to prepare the doctors for their first clinics. GPs in training reported that this made them more prepared for their first clinics.
- Provision of a wide range of additional visiting services including sexual health clinics, podiatry, orthopaedic clinics, audiology clinics and counselling. This assisted patients to access services locally and avoid time consuming trips to the general hospital or other health services. An urgent care hub was also located on the premises for patients who needed to see a GP or nurse when appointments were not available at their own practice.
- The practice recognised the importance of providing services closer to the patient. When designing the medical centre additional space was provided to accommodate a growing population and additional local services.
- An innovative approach to training qualified doctors. This involved running a simulated clinic with case studies to prepare the doctors for their first clinics. GPs in training reported that this made them more prepared for their first clinics.
- Prompt and effective response to patient feedback. When feedback from the national patient survey identified difficulty in accessing the practice by phone the practice purchased a new telephone system, revised staff rosters to provide more staff to answer the phone and monitored call response time. Feedback from patients during inspection identified improvement in accessing the practice by phone.
- Operation of enhanced recall systems to ensure patients did not miss important tests or treatments. For example, GPs and nurses used information from hospital departments to remind patients who required a repeat test or scan at infrequent intervals. The risk of patients missing an important test was reduced.
- An improved and expanded prompt system to remind patients when they required tests and treatment. This was used to support patients with complex medical needs and long term medical conditions. For example, GPs were prompted to review whether a patient diagnosed with dementia required another person to act on their behalf in making decisions about care and treatment.
- Robust arrangements for use of technology to exchange information with hospital departments. Use of both e-mail and telemedicine with a range of hospital departments in a secure transfer system. This reduced the need for some patients to visit hospital outpatients and information returned from the hospital enabled prompt follow up for the patient with their named GP.
- Provision of a health information zone managed by the PPG. This included a computer terminal for patients to access information on local services and health promotion literature. The PPG members assessed useful information, often influenced by their discussions with other patients, to hold. They agreed what could be displayed with the practice. This information zone was for patients run by patients. Provision of services to 10 Syrian refugees and two local traveller communities. Feedback from these groups was positive. Particularly from members of the travelling community who benefitted from seeing their named GP for continuity of care. The practice record system alerted staff to book 30 minute appointments for members of the Syrian community and to book a translator who spoke the appropriate dialect.

We saw several areas of outstanding practice including:

**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 outstanding for providing safe services.

- Patients were protected by a comprehensive safety system and a focus on learning from others, and sharing learning, when something goes wrong. Learning from significant events was shared with other local practices and learning from the other practices was shared with the practice team.
- All staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice led a project to improve incident reporting related to receipt of hospital letters. This resulted in more prompt receipt of hospital information and enabled GPs to deliver care more safely.
- The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation. Staff were encouraged to participate in learning to improve safety
- Information about safety was highly valued and was used to promote learning and improvement. All staff were encouraged to be open and transparent and fully committed to reporting incidents. Incident reporting was thorough and analysis of incidents gave a robust picture of safety.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.
- There was a proactive approach to anticipating and managing risks to service users. For example, the safety of dispensing of medicines was regularly reviewed and safety checks of the premises were timetabled and carried out in a robust manner.
- Systems for managing medicines were robust and when prescribing errors occurred they were investigated thoroughly and learnt from.
- 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. There was a strong focus on openness and transparency when something went wrong.
- The practice had comprehensive systems in place to keep patients safe and safeguarded from abuse. All staff were appropriately trained to identify abuse and knew who to report any concerns to.

Outstanding



# Summary of findings

- Risks to patients were assessed and well managed. Safety of premises and equipment was a top priority and the practice had robust planned maintenance programmes in place.

## Are services effective?

The practice is rated as outstanding for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients.
- Data showed that the practice was performing highly when compared to practices nationally. For example, they had achieved 100% of the indicators for supporting patients with long term conditions.
- The staff team demonstrated a collaborative approach to deliver high quality care to patients with complex needs. For example, by seeking advice and support for these patients from visiting professionals.
- Staff were consistent in supporting patients to live healthier lives. For example, by promoting health checks for patients aged between 40 and 70.
- The practice had an enhanced system of recalling patients for tests and treatments. For example, if a patient was required to attend for a hospital test the recall system logged this and the GP reminded the patient.
- The practice used innovative and proactive methods to improve patient outcomes and worked with other local providers to share best practice. For example, by using telemedicine and e-mails to communicate with hospital specialists. This assisted patients who found it difficult to attend the general hospital which often involved a two hour round trip.
- 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. The practice encouraged and supported staff to expand their skills and obtain additional qualifications. For example, GPs and nursing staff were trained to initiate insulin for patients diagnosed with diabetes.

Outstanding



# Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

## Are services caring?

The practice is rated as good for providing caring services.

- 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.
- Views of external stakeholders were very positive and aligned with our findings.

Good



## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example by providing an area where other providers could offer clinics and services.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, by implementing revised staff rosters and a new telephone system to improve access to the practice when booking appointments.
- 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.
- Translation services were easily accessed and some frequently used instructions and phrases were translated into the two languages frequently used by patients.
- 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.

Good



# Summary of findings

## Are services well-led?

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

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- The practice had a very engaged patient participation group (PPG) which influenced practice development. For example, PPG members had been involved in the planning and design of the practice premises. This had resulted in additional design features such as turning circles in corridors to assist patients in wheelchairs and those using mobility scooters.
- There was a strong culture of risk management that 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
- There was a strong focus on continuous learning and improvement at all levels.
- There was a high level of staff satisfaction and staff were proud to work at the practice. Staff were encouraged, and given opportunities, to contribute to the future development of the practice.
- The leadership drive a culture of continuous improvement. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment. This included a focus on bringing services closer to the patient.
- Continuity of care was valued by the practice team and patients. The personal list system was embedded in the practice and delivered personalised care for all patients.

Outstanding



# 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 outstanding for the provision of safe, effective and well led services and was thus rated outstanding overall. This rating applies to all population groups.

- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- There were close links with the podiatry service to ensure that patients received additional support from their GP if the podiatrist had any concerns about other health matters.
- All patients aged over 75 had a named GP and were encouraged to see their named GP to facilitate continuity of care.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Care plans were in place for older patients with complex medical problems.
- The practice worked closely with the local community hospital to support older patients who needed short term care in hospital.
- The practice supported registered patients who moved into local care homes and wished to retain the services of their usual GP.

Outstanding



### People with long term conditions

The practice is rated as outstanding for the provision of safe, effective and well led services and was thus rated outstanding overall. This rating applies to all population groups.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Diabetes care indicators showed that 88% of patients with diabetes were meeting target cholesterol levels compared to 84% average for the CCG and 80% national average. Data also showed that 96% of patients diagnosed with diabetes had received a foot examination compared to the CCG average of 90% and national average of 88%.
- Longer appointments and home visits were available when needed.

Outstanding





# Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. 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.
- The practice undertook additional tests and treatments for this group of patients and used a set of prompts in the patient records to enhance the care provided. For example, the system ensured new mothers who were diagnosed with diabetes received an additional blood test six weeks after giving birth.
- The practice used an expanded recall system to reduce the risk of patients with long term conditions missing follow up tests and treatments.

## Families, children and young people

The practice is rated as outstanding for the provision of safe, effective and well led services and was thus rated outstanding overall. This rating applies to all population groups.

- 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 80%, which was comparable to 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.
- We saw examples of the practice making appropriate referrals to the local authority when GPs had concerns about child safety.
- A dedicated family planning clinic was available at the practice.

Outstanding



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

The practice is rated as outstanding for the provision of safe, effective and well led services and was thus rated outstanding overall. This rating applies to all population groups.

Outstanding



# Summary of findings

- 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.
- Telephone appointments were available for patients who found it difficult to attend the practice and these extended beyond 6.30pm on three evenings every week.
- There were extended hours clinics held every Friday morning from 7.30am and Friday evening between 6.30pm and 7pm.
- The practice actively promoted smoking cessation and 189 patients had quit smoking in the last year.
- A range of health promotion opportunities were available and encouraged when appropriate. For example GPs referred patients for exercise classes.

## People whose circumstances may make them vulnerable

The practice is rated as outstanding for the provision of safe, effective and well led services and was thus rated outstanding overall. This rating applies to all population groups.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 81% of patients diagnosed with a learning disability had received an annual health check in the last year (58 patients out of 71).
- Feedback about practice services from members of the travelling community was positive. Members of this community had a named GP and were identified to ensure their need for prompt appointments was met.
- 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. 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. We saw records of safeguarding concerns being escalated to ensure the patient received relevant support.
- Translation facilities were available and actively promoted. When a patient required a translator their records were annotated to enable staff to book a translator in advance of an

Outstanding



# Summary of findings

appointment. Some frequently used instructions and phrases were translated into a Syrian dialect and Polish because the practice was aware that members of these communities required additional support when attending for appointments.

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

The practice is rated as outstanding for the provision of safe, effective and well led services and was thus rated outstanding overall. This rating applies to all population groups.

- 97% of patients diagnosed with a severe and enduring mental health problem had a care plan agreed with them compared to the CCG average of 86% 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 and included additional checks within the care plans. For example, the GPs checked whether the patient required a person to act as lasting power of attorney for decisions about care and treatment.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Counselling and talking therapy services were available at the practice.
- 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.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- All staff had received training in the Mental Capacity Act (2005) and understood the requirement to assess capacity of patients to make decisions about their care and treatment.

**Outstanding**



# Summary of findings

## What people who use the service say

The most recent national GP patient survey results were published in January 2016. The results showed a mixed picture of how the practice was performing compared to local and national averages. Patients reported high levels of satisfaction with the care they received. However, access to the practice by telephone and opening hours received a less favourable response. Two hundred and fifty nine survey forms were distributed and 121 were returned. This represented 0.8% of the practice's patient list and a 47% response rate.

- 68% of patients found it easy to get through to this practice by phone compared to the national average of 73% and CCG average of 84%.
- 89% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85% and CCG average of 89%.
- 85% of patients described the overall experience of this GP practice as good compared to the national average of 85% and CCG average of 88%.
- 79% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79% and the CCG average of 82%.

The practice was aware of their lower than average rating for gaining telephone access. They had responded by installing a new telephone system and reorganising staff rosters to provide more staff to answer telephone calls at peak times.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 35 comment cards which were all positive about the standard of care received. Patients were consistently complimentary about the continuity of care they received from their GP. They also said that staff were kind and helpful.

We spoke with 10 patients during the inspection, including two members of the patient participation group (PPG). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). All 10 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

We reviewed four months results from the friends and family recommendation test. This showed that 90% of the 67 respondents were likely or extremely likely to recommend the practice to others.

## Outstanding practice

- Operation of enhanced recall systems to ensure patients did not miss important tests or treatments. For example, GPs and nurses used information from hospital departments to remind patients who required a repeat test or scan at infrequent intervals. The risk of patients missing an important test was reduced.
- An improved and expanded prompt system to remind patients when they required tests and treatment. This was used to support patients with complex medical needs and long term medical

conditions. For example, GPs were prompted to review whether a patient diagnosed with dementia required another person to act on their behalf in making decisions about care and treatment.

- Robust arrangements for use of technology to exchange information with hospital departments. Use of both e-mail and telemedicine with a range of hospital departments in a secure transfer system. This reduced the need for some patients to visit hospital outpatients and information returned from the hospital enabled prompt follow up for the patient with their named GP.
- Provision of a health information zone managed by the PPG. This included a computer terminal for

# Summary of findings

patients to access information on local services and health promotion literature. The PPG members assessed useful information, often influenced by their discussions with other patients, to hold. They agreed what could be displayed with the practice. This information zone was for patients run by patients.

- Provision of services to 10 Syrian refugees and two local traveller communities. Feedback from these

groups was positive. Particularly from members of the travelling community who benefitted from seeing their named GP for continuity of care. The practice record system alerted staff to book 30 minute appointments for members of the Syrian community and to book a translator who spoke the appropriate dialect.

# Windrush Medical Practice, Windrush Health Centre

## 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, a practice nurse specialist adviser 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.

## Background to Windrush Medical Practice, Windrush Health Centre

Windrush Medical Practice is located in a purpose built health centre that was opened in 2012. The practice occupies part of the grounds of Witney community hospital and is located over three storeys. The ground floor of the premises is sub-let to NHS property services where a range of health and social care services are located. These include podiatry and an urgent care 'hub' where patients from GP practices in West Oxfordshire can obtain a GP or nurse appointment when there are none available at their own practice. A commercial pharmacy is also located on the ground floor. The practice occupies the first and second floors of the centre. Treatment rooms and consulting rooms are on the first floor. Access to the practice is gained from either stairs or two lifts, one of which is large enough to accommodate an emergency trolley. There is parking

available in the hospital grounds and a large public car park, offering free parking, is located to the rear of the practice. Bus routes run along the main road in front of the practice.

There are approximately 14,500 patients registered with the practice and the registered population is increasing. The practice is aware of the expansion of the local community and the premises are designed to accommodate further growth in the patient list. The age distribution of the registered patients is largely similar to the national averages. Although there is a slightly higher than average number of patients in the age group 65 to 79. National data does not show income deprivation to be a significant issue but the practice is aware of, and is able to identify, their patients with income deprivation issues. The practice serves two local traveller communities and a small group of Syrian refugees. Over 92% of the population are white British.

There are eight GP partners and three salaried GPs at the practice. Six of the GPs are male and five are female. There are 10 nurses (all female) at the practice who carry out various roles including medical research. Two of the nurses are qualified as independent prescribers and a third nurse is close to completion of their prescribing qualification. Four health care assistants and an assistant practitioner complete the nursing team.

The practice is a dispensing practice and the dispensary serves approximately 2,700 of the registered patients who live more than a mile from a pharmacy. The dispensary is staffed by a dispensary manager and a team of six dispensers and dispensing assistants. In addition there are two dispensary drivers who deliver prescriptions to

# Detailed findings

patients who cannot attend the practice. The practice manager is supported by a large team of 32 administration and reception staff. Some of these staff are employed as cover for absence and holidays.

The practice offers both teaching of medical students and training for qualified doctors who wish to become GPs. Two trainee placements are available.

The practice is open for telephone calls from 8am every weekday morning and the doors open at 8.15am until 6.30pm from Monday to Friday. Appointments are available from 8.20am until 5.50pm each day. Extended hours clinics are held on a Friday morning from 7.30am until 8am and on Friday evening between 6.30pm and 7pm. In addition extended hours telephone consultations are offered on Monday, Wednesday and Thursday evenings from 6.30pm to 7pm

The practice has opted out of providing out of hours services to their patients. The out of hours service is provided by Oxford Health NHS Foundation Trust and is accessed 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: Windrush Medical Practice, Welch Way, Witney, Oxfordshire, OX28 6JS.

The practice was subject to a CQC inspection in September 2014 when the CQC was testing new inspection methodologies and ratings were not applied. No concerns were identified at the inspection in 2014. This inspection was undertaken to check whether the practice was meeting regulations and to apply a rating to the service.

## 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.

This was the second inspection of Windrush Medical Practice. The practice was last inspected in July 2014 as part of the pilot process for the CQC comprehensive inspection programme. At that time a rating for the practice was not applied and no breaches of regulations were found.

## 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 8 October 2015. During our visit we:

- Spoke with a range of staff. These included, seven GPs, two nurses, a health care assistant, the deputy patient services manager, facilities manager, dispensary manager, a dispenser and three members of the administration and reception team.
- Also spoke with 10 patients who used the service.
- 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 records relevant to the management of the service.
- Carried out observations and checks of the premises and equipment used for the treatment of patients.

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:

# Detailed findings

- 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 and responding to safety alerts and concerns. Safe delivery of services was a priority for practice and safety concerns raised were valued as integral to learning and improvement.

- 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. We saw examples of the incident report form being completed by different groups of staff. For example, when a member of reception team had not taken sufficient detail about the death of a patient they instigated the completion of a significant event record. 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. Records showed us that significant events were sometimes used to initiate audits. For example, the practice identified that there was a risk of medicines interactions when patients received a medicine prescribed by a hospital doctor in addition to their regular repeat medicines. Consequently they undertook an audit of medicines prescribed for patients attending a specific outpatient service.
- There was a robust system in place to receive, act upon and record action arising from safety alerts. We saw minutes of meetings where the GPs reviewed the actions taken to address safety alerts. For example, those which required review of patients taking specific types of medicine. The practice manager retained a record of all safety alerts received and this contained details of the action taken.

- One of the GPs at the practice had led a project for the locality group which involved the recording and reviewing of any safety concerns. The project involved use of a nationally recognised data collection system called 'Datix'. The analysis of the reported incidents led to an improvement in the return of outpatient letters from the local hospital to GPs in Oxfordshire. This meant that GPs received more timely information to support patients who had attended hospital and reduce the risk of their hospital treatment not being followed up.

We reviewed safety records, incident reports, patient safety alerts 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, an additional step had been added into the process for receiving the notifications of the death of patients following an incident where the GP had not been asked to attend to confirm the cause of death. We saw records of the incident being reviewed and the actions agreed by senior leadership in the practice. Reception staff we spoke with were able to tell us what had been done to prevent recurrence and how they had received a briefing on the new processes to ensure learning was shared with the whole practice team.

The practice took part in sharing learning across the locality. The practice manager was part of a group that reviewed significant events that occurred in the West Oxfordshire locality and other members of the team shared learning through both formal and informal networks. For example, the practice learnt from a near miss at a neighbouring practice where a young patient could have received an additional immunisation that was not required. The practice built in an additional check before administering this series of immunisations to ensure only the right number were administered. They also sent details of the near miss to the National Reporting and Learning System centre so other practices could be alerted to the issue. We also saw that learning had been shared with the practice team when a neighbouring practice alerted practice managers to an issue of confidentiality regarding patient's accessing their medical records. This prompted the practice to check medical records before releasing them to the patient to ensure third party information which was designated as confidential was not included.



## Are services safe?

### Overview of safety systems and processes

The practice demonstrated an effective safety management culture. There were 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 and guidance on the procedure to follow to lodge a safeguarding concern was available in all clinical rooms. 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 we were given two examples of recent attendance at safeguarding case conferences. When it was not possible for GPs to attend safeguarding conferences they always provided reports where necessary for other agencies. Staff demonstrated a clear understanding of their responsibilities to report safeguarding concerns. Nine of the 10 GPs were trained to child protection or child safeguarding level three. The tenth GP was working towards this level having just returned from maternity leave. Practice nurses were all trained to a minimum of level two and three were trained to level three. The reception and administration staff were all trained to level one. Minutes of a practice meeting from both January and March 2016 demonstrated that GPs at the practice escalated safeguarding concerns when they felt the safeguarding authority needed to take further action. These minutes also showed us that concerns regarding both vulnerable adults and children were shared by the practice team. The practice records system identified patients who were subject to any concerns arising from consultations with the GPs and nurses.
- 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).
- The practice maintained high standards of cleanliness and hygiene. We observed the premises to be clean and tidy. Cleaning equipment was maintained in good order and was stored securely along with cleaning materials. The practice held risk assessments and data sheets for all the cleaning materials in use. There was a robust monitoring system to review cleaning standards and a detailed cleaning schedule was followed. One of the practice nurses 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 evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). 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 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 an Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. A third nurse was in training to become an independent prescriber. The nurse prescribers 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. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). We noted that some of the PGDs had expired. The practice was aware of this and had put arrangements in place for individual authorisation for administration of the medicines and vaccines affected by a qualified prescriber. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription (PSD) or direction from a prescriber. (A PSD is a written instruction, from a qualified and registered prescriber



## Are services safe?

for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).

- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. The dispensary manager was trained to pharmacy technician level and was subject to continuing professional development. Any medicines incidents or 'near misses' were recorded for learning and we saw evidence of this when dispensing errors occurred. The practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). The dispensary operated a prescription delivery service to patients who were unable to attend to the practice. The system we saw included a secure return procedure. If the patient was not able to receive their prescription the practice followed this up to ensure the patient was safe and did not require any support. We were told of an incident where the delivery driver was concerned when the patient did not take receive their prescription and they found the patient was in need of medical assistance.
- The practice held stocks 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 nine 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

The practice demonstrated a firm commitment to identifying, assessing and managing risk. There were a range of systems and processes in place to ensure 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 staff room. This identified local health and safety

representatives. The practice had up to date fire risk assessments and carried out regular fire drills. 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). We saw records of the regime the practice followed in response to their legionella assessment. This included regular flushing of water systems and checking of hot and cold water temperatures.

- 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 at peak times of the day to respond to incoming phone calls from patients wishing to make appointments.
- The practice undertook regular premises checks to identify and act on risk. The facilities manager showed us their monitoring reports of these checks. When a risk was identified we saw that action was taken to address it. For example, when the premises check identified a faulty lock to the dispensary, placing security of medicines at risk, immediate action was taken to replace the lock.
- There were records of maintenance to the premises and equipment. For example, we reviewed the records for servicing the heating system, boilers, air conditioning units and patient lifts. We saw that maintenance was carried out in accordance with manufacturers' recommendations. The facilities manager held a timetable for all essential maintenance which meant that the risk of building and equipment failure was reduced.

### 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.



## Are services safe?

- All staff who came into contact with patients received basic life support training. The practice had carried out a risk assessment for office staff who did not work directly with patients. This showed us that these staff were not placed in a situation where they may have to use basic life support skills to support a patient or colleague in distress because there was always a colleague on site who was trained.
- The practice held emergency medicines and these were available in the clean utility room. One of the trainee GPs had undertaken an audit of the emergency medicines held and we saw that the stock of medicines had been enhanced following their review. There was a system in place for a member of the dispensary team to regularly check, and record the outcome of their check, the emergency medicines. We checked these medicines during our inspection and found they were all
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There were records of this emergency equipment being checked on a regular basis. A first aid kit and accident book were available.
- 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. The staff we spoke with were aware of their role in contributing to maintaining services.



# 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 100% of the total number of points available. The practice exception rates for the indicators was 7% compared to the national average of 9% (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).

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 better than both local and national averages. The practice achieved 100% compared to the CCG average of 94% and national average of 89%. The exception rates were similar to national and local averages across all the diabetes indicators.
- Performance for mental health related indicators was better than both local and national averages. For example, 97% of patients with severe and enduring mental health problems had an agreed care plan in place compared to the CCG and national average of 89%.
- Performance for chronic obstructive pulmonary disease (COPD which is a type of lung disease) was better than

both local and national averages. For example, patients with this condition who had received an assessment of breathlessness was 94% compared to the CCG average of 91% and national average of 90%. This was achieved with less than a 1% exception rate compared to the CCG exception rate of 14% and national exception rate of 11%. Therefore, more patients were receiving this assessment.

- Performance for patients who had a stroke or mini stroke was better than local and national averages. For example the number of these patients with a blood pressure reading in target range was 92% compared to the CCG average of 89% and national average of 88%. Again the practice exceptions from this measure were 3% below the CCG average and 2% below the national average. The practice exception rate was 25 compared to the CCG 5% and national average of 4%.

There was evidence of quality improvement including clinical audit.

- There had been seven clinical audits undertaken in the last year. Three of these 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 carried out an annual audit to ensure patients who had reduced immunity received a pneumococcal vaccination every five years to reduce the risk of them contracting pneumonia.
- Another audit was undertaken annually to check the thyroid function of patients diagnosed with hypothyroidism. This ensured patients with this condition were reviewed and any additional care or treatment or adjustment to their prescription was followed up.
- We also saw that an audit prompted alerts being placed on patient records for those who were taking a specific medicine. The alert directed GPs and nurses to check possible medicine interactions and advised caution when undertaking tests.
- The practice had an audit programme in place that included repeating audits from 2015 to ensure action identified had been carried out and improvements



# Are services effective?

## (for example, treatment is effective)

sustained. New audits were also timetabled. For example, an audit to ensure patients who had been seen at the urgent care hub required immediate support and treatment.

- Information about patients' outcomes was used to make improvements such as the practice had identified that follow up tests and treatments for patients who were not subject to an annual health review, or on a long term condition register, were occasionally missed. Consequently they introduced an extended recall system to reduce the risk of such tests and treatments being overlooked. For example, when a patient attended hospital for a scan and the hospital requested the patient repeat the scan in two years' time this was added to the recall system to remind the GP to contact the patient and check they were booked for their scan.
- One of the GPs took a lead in ensuring patients with long term medical conditions received effective care and support. They had developed an enhanced recording system that identified a wide range of tests, treatments and support that patients with these conditions required. This extended to other recording templates for a wide range of checks and follow ups. The additional prompts were influenced by both NICE guidelines and audits. These recording templates extended beyond the standard records used to satisfy the QOF indicators. For example, the practice added a section on the record template to confirm if a lasting power of attorney was appointed for patients diagnosed with dementia. They had also added sections relating to the patient, and carer, wishes for end of life care. When a patient attended for review of their contraceptive regime the recording template prompted the GP or nurse to discuss the option of long term contraception as an alternative. The template used for diabetic reviews prompted GPs and nurses to link to the smoking cessation record if the patient was a smoker. This ensured smoking cessation advice was followed up and opportunities to stop smoking were explored in detail. In addition there was a prompt for patients prescribed insulin to be reminded to carry their 'insulin passport' with them in case they required emergency treatment and were unable to state they were taking insulin. We also saw that the records for patients attending for an ante-natal check contained a prompt to ensure that if

the patient was diabetic that they received an additional blood test between six and thirteen weeks after delivery. This also prompted an entry into the enhanced recall system.

### 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. Dispensary staff received training relevant to dispensing. For example, two dispensers had recently attended a training day covering endorsing prescriptions. There was a training programme for all staff. Staff we spoke with were fully briefed on their training schedule and were able to describe the training programme they were following.
- 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. New staff received a formal review of their performance after three months in post and we saw the records of these included the development needs for staff.
- 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.



# Are services effective?

## (for example, treatment is effective)

- Staff were encouraged to expand their skills with specific training. For example, two dispensary staff had been supported on a level two dispensing course and two GPs and a nurse had taken training to initiate insulin for patients diagnosed with diabetes.
- The practice supported qualified doctors in training to become GPs. One of the GP trainers had developed, and implemented, a training surgery exercise for new trainees. We saw that this included case studies within a simulated clinic. We noted that feedback from trainee GPs and neighbouring trainers with whom it had been shared was very positive.

### 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.
- We saw numerous recorded examples of the practice GPs using e-mail and photographs to share information and gain advice from hospital specialists. This helped reduce the need for patients to attend hospital outpatient departments which often involved a two hour return journey to the hospital. For example records of sleep apnoea tests were mailed for advice and pictures of dermatological conditions sent to the dermatology department. The practice held a register of the contact details for approximately 50 other services and this also detailed the availability of the staff at the service to respond to e mails and telephone contact. There were examples of the GPs sending photographs of skin conditions to the dermatology department and receiving advice on diagnosis and treatment which enabled them to support the patient without the need for the patient to attend hospital. There were robust governance arrangements in place to ensure communication of patient information was secure. We also noted that the practice linked information coming back from hospital's into their patient recall system.

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.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). The practice had undertaken MCA training for all staff in September 2015. When providing care and treatment for children and young patients, staff carried out assessments of capacity to consent in line with relevant guidance.
- 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. We saw examples of GPs being involved in decisions to appoint people with power of attorney for health matters for patients assessed as lacking capacity to make their own decisions on health matters.
- The process for seeking consent was monitored through patient records audits.

### 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 received support or were signposted to the relevant service.
- Diabetic education services were available on the premises provided by a diabetes specialist nurse. Patients were identified who could benefit from an increase in exercise. These patients were offered referral to exercise classes.
- Smoking cessation advice was available from trained counsellors. The practice had identified 15% (1864) of their patients aged over 16 as smokers. Of these 1848



## Are services effective? (for example, treatment is effective)

had been offered some form of advice to encourage them to stop smoking during the last year. Three hundred and thirty nine had attended smoking cessation clinic and 187 had quit smoking.

The practice's uptake for the cervical screening programme was 80%, which was comparable to 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 using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The breast cancer screening rate for women screened in the last 36 months for the practice was 81% compared to the CCG average of 75% and national average of 72%. For bowel screening within 30 months the practice achievement was 64% which was higher than the CCG average of 59% and national average of 58%. 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 had identified 71 patients with a learning disability. All of these patients were invited to have a

physical health check. Data showed that 58 had taken up the offer and had a physical health check in the last year. This was 81% of the total. The practice recorded if the patient had declined the offer of the health check.

The practice was committed to offering early dementia screening to patients identified with a risk of developing dementia. There were 444 patients in this group. Of these 119 had declined the offer of the screening check. The practice data showed that 25 patients were screened positively and were offered appropriate treatment and support at the earliest possible opportunity.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 97% compared to the CCG averages of 90 to 97%. For five year olds the practice range was from 93% to 99% compared to 92% to 98%.

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. There were 4,716 patients in the aged 40 to 74 group who were eligible for the health check. Of these the practice had completed 2,661. We noted that 1,909 patients who were offered the check either, declined, did not respond or did not attend when invited.



# 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 35 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. Over half the patients who completed the comment cards were complimentary of the continuity of care they received by seeing the same GP for the majority of their appointments. They felt this meant the GPs had a better understanding of their needs and treatments. There were examples given of urgent appointments with the patient's usual GP for those patients with long term conditions.

We spoke with two 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 published in January 2016 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%.

- 91% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 98% 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%.
- 90% 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 national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average 93% national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

### 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:

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average 87% and national average of 85%.

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

## Are services caring?

- 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.
- Information leaflets were available in easy read format.
- A range of information leaflets were used by GPs to support the advice they gave to patients. Three of the patients we spoke with and five who completed comment cards said they found these very useful to support their decision making after their GP had explained their treatment proposals.

### **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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 340 patients as carers this was just over 2% of the practice list. A monthly carers clinic was held at the practice. The advisor who attended was able to give carers advice on support services and benefits available to the carer. GPs and nurses at the practice were able to book carers into this clinic to obtain additional support and advice. Patients could attend the clinic without referral and if the advisor assisted a carer who had not registered as such with the practice they ensured they did so. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. 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.

# 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, when the practice opened their current premises they worked with the CCG and local Trust to provide additional services from the ground floor. These services provided care closer to the patient's homes. They included an urgent care centre, podiatry, endoscopy and ultrasound. Outpatient clinics were also held at the practice for patients of neighbouring practices as well as those from Windrush. These included, audiology and orthopaedic clinics.

- The practice offered extended hours clinics on Friday morning and Friday evening 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.
- 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 accessible facilities, a hearing loop and translation services available. Direction signs within the practice contained braille for blind patients to use.
- The practice had two lifts for patients to use when attending to see their GP or other services located on the first and second floors.
- There were services on site providing specialist family planning advice, counselling and sexual health advice. Early dementia screening was available and encouraged. Podiatry services also operated from the ground floor. If the podiatrist had any concerns about a patient they were treating they had immediate access to the patient's named GP to seek advice or to ask the GP to see the patient. If a GP required podiatry advice for a patient they were consulting they were able to ask the podiatrist to join the consultation or to see the patient after their consultation.

- The practice was designated to provide a service to 10 of Syrian refugees who resided in Witney. They also provided services for two local travelling communities. The practice had taken part in a local Healthwatch review of services for this patient group. Members of this community were identified on the practice record system and all had a named GP. The practice was aware that these patients might not receive care and treatment if they were not seen promptly. By identifying their needs the reception staff were prompted to offer an urgent appointment whenever a member of this group made contact with the practice. If these patients had difficulty with reading and writing this was noted and staff ensured any advice or instructions were given verbally.
- Services were provided to a local children's home. These patients did not have family support and had a range of complex health and social needs.
- The practice had prepared a document containing a number of frequently used instructions and requests translated into a language commonly used by the Syrian refugees. The document also contained similar sections for Polish patients. For example, phrases such as you will need an appointment for a blood test were translated into both languages.

### Access to the service

The practice was open to take telephone calls from 8am and the doors opened at 8.15am and 6.30pm Monday to Friday. Appointments were from 8.20am to 12pm every morning and 2pm to 5.50pm daily. Extended hours appointments were offered from 7.30am every Friday and from 6.30pm to 7pm also on a Friday. The GPs also offered telephone consultations after 6.30pm on Monday, Wednesday and Thursday. For example, three GPs undertook telephone consultation between 6.30pm and 7pm on a Monday. 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 published in January 2016 showed that patient's satisfaction with how they could access care and treatment had been below local and national averages.

- 67% of patients were satisfied with the practice's opening hours compared to the national average of 78%.

# Are services responsive to people's needs?

(for example, to feedback?)

- 68% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

The practice was aware of the feedback from patients. They had installed a new telephone system and revised staff rosters to make more staff available to answer patient calls. We looked at data from a three month period of December 2015 to February 2016. This showed that over 95% of calls to the practice were answered within seven seconds. Five of the patients who completed comment cards said they had noticed a significant improvement in getting through to the practice by phone. All of the 10 patients we spoke with commented that they did not experience difficulty contacting the practice by phone in recent times. The PPG had fed back to the practice that members of the patient reference group that comprised over 130 members had provided positive feedback about an improvement in calls to the practice being answered promptly. The practice undertook monitoring and auditing of the time taken to pick up an incoming telephone call. We noted that over 90% of calls were answered within seven seconds.

The practice had introduced evening telephone consultations on three days a week in response to the patient feedback regarding opening hours.

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

## 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. The complaints procedure was displayed in the patient information area in the waiting room, in the practice leaflet and on the patient website.

We looked at 16 complaints received in the last 12 months and found these were satisfactorily handled. They were all dealt with in a timely way and were dealt in an open and transparent manner. 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 some items removed, incorrectly, from their prescription. When the patient alerted the practice to their complaint the GP concerned called the local pharmacies to ensure the error could not be repeated. The patient chose to have their prescription dispensed and received an apology from the practice.

# Are services well-led?

Outstanding



(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 personalised care and promote good outcomes for patients.

- The practice had a mission statement which was displayed 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.
- Leaders at the practice worked closely with the CCG and other practices in the area to drive improvements for the local population. For example, when the practice planned and opened their current premises they included additional space to house the urgent care hub. This benefitted practice patients from neighbouring practices when the practices had filled their appointments.
- The practice ran a system of each GP holding a personalised list of patients to support continuity of care. Patients who completed CCG comment cards and those we spoke with during our visit valued this and told us they benefitted from seeing the same GP who had detailed knowledge of their needs. We saw that the practice made efforts to ensure patients received appointments with their named GP even when booking an urgent on the day appointment. Two of the patients we spoke with told us they had been able to see their named GP that day having called for an appointment in the morning. The practice strategy had a long term commitment to maintain this system.

### 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.
- There was a clear leadership system which the GPs and senior managers owned. Staff we spoke with had a clear understanding of which GP led on specific areas. One of the GP partners took a lead role as business partner and supported the practice manager in managing systems

that supported delivery of safe care and maintained quality. The practice was able to demonstrate that GPs paid significant attention to their lead roles. For example, the GP with responsibility for the Quality and Outcomes Framework and services to patients with long term or complex medical conditions had developed recording templates that captured additional information or prompted additional treatments for patients in these groups.

- Practice specific policies were implemented and were available to all staff. These policies were subject to regular review and those we looked at had been reviewed and updated in the last year.
- A comprehensive understanding of the performance of the practice was maintained and was used to maintain high quality services and develop new services. For example, the practice was aware of how many patients attended the urgent care service located on the premises. GPs undertook audit of the patients who attended to ensure their attendance was appropriate and gain a better understanding of why they had not been able to obtain an appointment with their own practice.
- 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. A culture of risk management was evident. This was demonstrated by both clinicians and managers. For example, significant events were used a trigger for clinical audit. Management of premises and equipment risk was delegated to the facilities manager and they had robust systems and maintenance timetables in place to minimise risk.
- There were quarterly meetings of the whole practice team. The meetings covered a wide range of topics including learning from incidents and complaints, new developments at the practice and patient feedback. They also gave staff the opportunity to contribute to the future development of the practice.

### 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.

# Are services well-led?

Outstanding



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

They told us, and demonstrated that, 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. Staff also told us they were proud to work at the practice.

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.
- 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.
- Staff showed a commitment to the practice and to the welfare of patients registered with the practice. There were examples of non clinical staff acting to ensure the health and wellbeing of patients.

## 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 organised by the PPG and complaints received. The PPG met regularly submitted proposals for improvements to the practice management team. For example, the PPG identified a need for patient navigators assist patients to access the appropriate service within the practice. The practice supported the proposal and the PPG organised volunteers to act as guides. This helped patients to get to the appropriate service within the building and saved patients going to the wrong floor for their appointments.
- The PPG operated autonomously yet sought practice input and support constructively. The leaders of the PPG established their own agenda's and ran their own meetings on a regular basis. They invited input from the GPs and managers for items and issues either by asking staff to attend their meetings or meeting the GPs or practice manager after their meetings to discuss specific topics. For example, to discuss feedback from surveys and put forward suggestions such as the need for patient navigators. We found that the practice had involved the PPG in the design of the medical centre. For example, the PPG members had been instrumental in ensuring turning circles were built into corridors. This helped patients who used mobility scooters and wheelchairs. The PPG managed a patient information area in the waiting room. This contained a wide range of information about community events, support groups, social services and health promotion. This facility was for patients and run by patients. When the PPG wished to add further information which patients had asked for to the area they sought practice approval. The information area also contained a suggestion box for patients labelled 'have your say'. Any comments received were fed back to the practice. In addition the PPG issued regular newsletters to more than 120 patients who had signed up for e-mail contact. Copies were kept in the waiting room. The practice provided a computer terminal within the information area which enabled patients to look up health promotion material, details of support groups and services in the area.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. The practice manager had a timetable of regular meetings with team leaders which ensured consistent messages were fed to the teams and feedback from teams was gathered in a

# Are services well-led?

Outstanding



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

systematic way. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management for example when one of the practice nurses developed the recall system to ensure GPs were alerted to patients who required treatment or tests to be followed up. Staff told us they felt involved and engaged to improve how the practice was run.

## 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. For example, one of the practice GPs led a project to capture any incidents or concerns about how GP practices interacted with the local hospital. As a result outpatient letters were received more rapidly from the hospital enabling GPs to provide follow up for patients with the information they needed from the outpatient clinic. Another GP had devised a simulated GP clinic exercise to prepare doctors in training for their first clinic. This had been shared with other practices and received positive feedback from the trainees and GP trainers at neighbouring practices.

The practice had built in expansion space at their premises to accommodate a growing population and provide more services locally for patients.

Audits were used to improve care and treatment and enhance safety. For example, an audit of patients taking specific medicines resulted in alerts being placed on their records to prevent medicine interactions.

The practice used shared learning from other local practices to improve safety. For example, building in an additional check to avoid administering too many immunisations for young patients. This arose from shared learning from another practice where a near miss had been reported. The practice learnt from their own significant event reporting system and ensured learning was shared with all staff. For example, additional checks were built in to the system to alert GPs of notification of deaths. This meant that if the GP was required to attend to certify a death they received a clear instruction in a prompt manner.

GPs were committed to delivery of safe and personalised care which took account of best practice and national guidelines. The implementation of enhanced recall systems, use of e-mail and telemedicine technology to reduce the need for hospital appointments and expanded treatment templates demonstrated this. Additional checks, treatments and tests were included in follow up consultations with a wide range of patients and the recall system prompted reminders such as recalling new mothers who were also diagnosed with diabetes for a blood test six to thirteen weeks after giving birth.