Dr Robertson and Partners

Quality Report

Marcham Road Health Centre
Marcham Road
AbingdonOxfordshire
OX14 1BT
Tel: 01235 522602
Website: www.marchamroadhealthcentre.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

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Summary of findings

Overall summary

Dr Robertson and Partners (known as Marcham Road Family Health Centre) is a GP practice situated on the site of Abingdon Community Hospital. The practice has approximately 12,500 registered patients. The practice provides a range of primary care services for patients.

We spoke with patients about their experiences of care at this practice and also looked at written feedback from patients about the quality of services. All of the patients we spoke with gave positive feedback about the practice and staff. We reviewed the results of the last patient survey undertaken in 2014. This showed patients were generally pleased with the service they received, but highlighted some areas for development. For example, making an appointment. The practice had taken steps to address these areas.

The practice was patient-focused in its approach to care and treatment. It provided information and support to help patients understand their care and treatment and help them make informed choices. The practice ran a number of specialist clinics to help patients manage their long term conditions. GPs and nurses had specialist areas of interest and provided advice and support to other GPs and nurses within the practice.The practice opted out of providing out of hours primary medical services for its patients. Outside of surgery hours patients were able to access emergency care from another Out of Hours service.

We found the practice did not operate effective systems to reduce the risk and spread of infection. The practice had an infection control lead and appropriate infection control policies and procedures. However, staff did not always following the procedures and audits to identify risk of infection were not regularly conducted. We found the provider was in breach of the regulation relating to infection control.

The practice met the needs of the population it served. Older patients at the practice had a named GP who oversaw their health and care needs. GPs conducted home visits to ensure patients who had difficulty accessing the practice received appropriate care and treatment. Patients with long term conditions told us their conditions were managed well. GPs and nurses had specialist areas of interest and training for long term conditions and provided specialist clinics to patients. Mothers and babies were supported by a service which had links with the local health visitors. Child immunisation clinics were run regularly.

The practice offered regular health checks to patients with poor mental health and patients with a learning disability. Patients who were carers were identified and offered additional support. The practice offered online appointment booking to ensure patients could access the service in a variety of ways. The practice did not offer any late evening or weekend opening to enhance access to patients who worked.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.

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 was safe. However, improvements were required with regards to systems to detect and prevent the spread of infection. The practice had medicines management procedures in place. There was a system to enable learning from incidents and accidents to improve patient care. The practice had internal safeguarding procedures to protect patients at risk of abuse. The practice identified and monitored clinical risks to patients. There were effective recruitment procedures in place.

Are services effective?

The practice was effective. The practice delivered care and treatment in line with recognised best practice and worked with other support services to provide a holistic service to patients. Staff received the necessary training and development for their role. The practice used data to analyse and improve outcomes for patients. There were a range of clinical audits, which identified where improvements to patient care and treatment could be made.

Are services caring?

The practice was caring. We spoke with 10 patients and looked at six comment cards during this inspection. Without exception, all comments and feedback was positive. Patients talked of a caring service and felt respected and treated with dignity and privacy. Patients talked of being well informed and involved in the decision making process of their care. The GPs were aware of how to support patients who lacked capacity to provide consent. The practice did not always make use of local services to support patients with specific communication needs.

Are services responsive to people's needs?

The practice was responsive to patients' needs. The practice had an active patient participation group (PPG). The practice asked patients and staff for suggestions to improve the practice and implemented changes. The practice understood the different needs of the population it served and acted on these to ensure the service supported patients. Patients could book appointments online, over the phone or in person. We saw the practice had a complaints policy which was accessible to patients and complaints had been responded to in line with the policy.

Are services well-led?

The practice was well led, GPs and nurses had clear lead roles and responsibility and provided advice and guidance to other staff in

Summary of findings

these areas. Staff were clear about what decisions they were required to make within their areas of responsibility. The practice encouraged on going development for GPs and nurses. The practice encouraged feedback from patients and learned from feedback when it was given. There were systems for managing business risks. The practice used available data to identify areas for improvement. There was no system in place to report back to the practice manager the results of these safety checks which had been prompted by medicines and equipment alerts. The practice met with other GP practices in the locality area to discuss the future provision of GP services and to identify opportunities to work together to improve services for patients.

Summary of findings

The six population groups and what we found

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

Older people
The practice operated a system where all patients over the age of 75 years were allocated a named GP. There was a monthly check to identify any patients who would be turning 75 and a letter was sent to these patients informing them of their named GP. One of the GPs within the practice took a lead for palliative care and provided advice and support to other nurses and GPs in this area. The GPs conducted home visits and visited patients at local nursing homes.

People with long-term conditions
Patients we spoke with who had long term conditions told us felt they received consistently suitable care. GPs and nurses held lead roles with respect of long term conditions. They shared learning and offered advice to other GPs and nurses. The practice offered a range of clinics run by specially trained nurses for patients with long term health conditions. The practice worked with specialist nurses and local support services to ensure that patients with long term conditions received required care and treatment.

Mothers, babies, children and young people
The practice offered clinics for mothers and babies. Staff worked closely with the local health visitors to identify children who were at risk of abuse and ensured they received appropriate care and treatment. GPs were aware of the legal framework within which they could assess the competence of children to provide consent to treatment.

The working-age population and those recently retired
The practice did not offer any evening or weekend appointments to improve access for the working age patient population. Patients of working age told us they preferred to take the early appointment (8.50am). The practice offered telephone appointments and an online appointment booking facility. The practice offered weight management clinics and referred patients to ensure they maintained a healthy lifestyle. Some clinical audits informed advice given to the working age population.

People in vulnerable circumstances who may have poor access to primary care
Staff described how they offered short term care and treatment for patients who had no fixed address. The practice had a system to

Summary of findings

ensure patients with a learning disability were identified and received an annual health check. The practice identified patients with caring responsibilities so that appropriate care and support could be offered.	
People experiencing poor mental health The practice worked with local mental health services to ensure patients were well supported. The practice offered regular health checks to patients with poor mental health and raised concerns if patients did not attend so that other agencies could provide appropriate support. Staff were informed about local support services and provided information to patients. The appointment system enabled patients with poor mental health to be seen quickly.	

Summary of findings

What people who use the service say

We spoke with 10 patients on the day of our inspection and received six comments cards from patients who had visited the practice within the previous two weeks. All comments and feedback were positive. Patients talked of a caring and responsive service. They felt safe, confident and respected in the care of the staff and were treated with dignity and had their privacy respected. Patients told us they were well informed and involved in the decision making process about their care. Patients said staff were helpful, kind and professional.

The practice results for the national GP patient survey 2014 showed patient satisfaction across a range of areas was lower than the regional average for the local clinical commissioning group (CCG). However, patient satisfaction with the way GPs and nurses treated them and the time given to them by nurses was higher than the regional average.

The national GP patient survey, 2014, showed lower than regional average patient satisfaction with experience of making an appointment. Patients we spoke with on the day of our visit felt the appointment system was effective but that it could be more flexible. Some patients felt late evening appointments would be beneficial especially those who worked during the day. Patients knew they could get a same day appointment for more urgent issues and request a GP of their choice for appointments in advance. Some patients told us the recent introduction of online appointment booking had improved their experience of accessing appointments.

Areas for improvement

Action the service MUST take to improve

- Implement a system to ensure staff adhere to the practice infection control policies. Introduce a system of regular audit and staff training in relation to infection control.

Action the service SHOULD take to improve

- Improve the availability of information for patients about how to complain.
- Improve the patient communication system to notify patients when they are being called into their consultation.
- Ensure translation and signing support services are offered to patients who may need them.
- Introduce a system to follow up on safety alerts to ensure that appropriate actions are taken.
- Ensure that prescription templates for the printer are kept securely at all times.
- Ensure completed audit cycles are undertaken to ensure actions, improvements and performance is reviewed.
- Improve access information for patients to ensure opening hours, appointment times and how to access out of hours services are clearly displayed in practice and on the practice website.

Outstanding practice

The practice had invested in a dermatoscope and trained a GP to use the equipment. Patients benefitted from a service that helped identify benign (non-cancerous) skin lesions.

Dr Robertson and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor. The team included a practice manager and another CQC inspector.

Background to Dr Robertson and Partners

Dr Robertson and Partners (known as Marcham Road Family Health Centre) is situated on the site of Abingdon Community Hospital, in Abingdon, Oxfordshire. The practice occupies a purpose built building and all patient services are located on the ground floor of the building. The practice has a dispensary, which is able to dispense medicines to those patients living more than one mile away from a pharmacy.

The practice provides a range of primary medical services to approximately 12,500 patients. Patients are supported by six partner GPs and two salaried GPs, three nurses, two phlebotomists (someone who is trained to take blood samples) and a team of administration staff. The practice opening hours were 8.30am to 18:30pm Monday to Friday. The practice had opted out of providing out of hours primary medical services for its patients. This was provided by another out of hours service.

The practice held a range of regular clinics including:

- Asthma Clinic:- Tuesday and Thursday afternoon- Monday, Wednesday, Thursday and Friday lunchtimes
- Diabetes Clinic - Monday and Wednesday mornings
- Heart Disease and Stroke Clinic - Tuesday, Wednesday and Thursday afternoons
- Child immunisation and surveillance clinic – Tuesday afternoons

The practice also offered minor surgery.

Dr Robertson and Partners, in line with other practices in the Oxfordshire Clinical Commissioning Group, is situated within a significantly less deprived area than the England average.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. These included organisations such as the local Healthwatch, NHS England and the clinical commissioning group.

We carried out an announced visit on 15 July 2014 between 8.30am and 6pm.

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

Detailed findings

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

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

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

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

Are services safe?

Our findings

Safe patient care

The practice received patient safety alerts from a number of organisations alerting them to safety issues around medicines and equipment. The practice had a policy on how these alerts would be communicated to staff. The practice manager and GPs told us how the alerts were dealt with in the practice, and the procedure they described was in line with the policy. The GP was able to give a recent example of where a safety alert had resulted in a number of patients' medicines being reviewed.

Learning and Improvement from safety incidents

Staff we spoke with told us there was a clear process to follow in the event of an accident or near miss (an accident that was closely avoided). The practice had a system to review significant events. We saw the reports of these events and were able to discuss with the practice manager and GPs the process for recording incidents. All serious events were discussed at quarterly significant event meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. We saw an example where a specific incident involving a lack of information on printed prescriptions had been investigated and suggestions had been sought about how to prevent the incident reoccurring. As a result, the prescription printing system within the practice had been changed to minimise future risks of patients receiving unclear information about dosage.

Reliable safety systems and processes including safeguarding

Children and adults were protected from the risk of abuse because the practice took reasonable steps to identify and prevent abuse from happening. The majority of staff had received an appropriate level of training for protecting vulnerable children and adults. One member of staff was aware of potential signs of abuse they would look out for, but was not aware of who the practice safeguarding lead was. The practice safeguarding policies covered children and vulnerable adults. There was a safeguarding file containing information about policies and procedures for staff to refer to. We spoke with staff about identifying and preventing abuse. They had a clear understanding of the different types of abuse and were able to describe the procedure to be followed if they suspected or witnessed any concerns. One of the GPs had a lead role for safeguarding. Safeguarding concerns were discussed at multi-disciplinary primary health care team meetings.

We saw information leaflets for patients on display in the waiting room regarding safeguarding children.

Monitoring safety and responding to risk

The practice employed three nurses, two worked part time. The lead nurse told us they were able to cover annual leave and sickness by part time staff working more hours. The practice operated a 'duty GP' system, this ensured that any patient who required urgent access to a GP was able to see or speak with the GP.

We spoke with staff about maintenance of the premises. There were contracts in place to maintain heating, electrical and water systems.

The practice manager told us there were business continuity plans to ensure a service was maintained for patients in the event of an emergency. For example, patient appointment lists were printed the evening before so that in the event of a power cut the practice would be aware of which patients were attending for appointments. We were told the GPs and nurses took hand written notes and updated patient records as soon as power was reinstated.

Medicines management

Safe management of medicines was in place. Nurses and dispensing staff were responsible for the management of medicines within the practice. Staff we spoke with were able to show us where medicines were stored and explained their responsibilities with respect to ordering, storing and checking medicines. Emergency medicines were kept securely in a locked cupboard. Medicine fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures. Controlled drugs were kept securely and access was restricted and recorded. We noted the stores of controlled drugs correctly tallied with the amount recorded in the practice's controlled drugs record books. Returned and expired controlled drugs were disposed of appropriately and a record kept.

Patients told us the process for obtaining repeat prescriptions was efficient and well organised. We spoke with dispensary staff and the GPs about repeat prescribing. All staff described the same repeat prescribing system. Patients told us they were informed when a medicines

Are services safe?

review was needed. A GP explained to us how they would encourage patients to attend for appropriate health checks if they were taking certain prescribed medicines which could have adverse side effects.

The practice participated in the dispensing service quality scheme (DSQS) and had undertaken an annual audit of the dispensary which had included staff competency checks. We saw records of one recorded dispensary incident. It had been fully investigated, lessons had been learnt and changes had been introduced to prevent a similar incident from occurring in the future.

In one unused, unlocked surgery we saw a large amount of blank computer generated prescription forms were left on top of the printer. This posed a risk to patient health and safety and was not in line with the NHS guidance on the security of prescription forms (2013). We brought this to the attention of the manager who stated they would investigate the incident straight away and remove the prescription forms to a secure location. Other [handwritten] prescription pads were kept securely in an area which was not accessible to patients. We noted that prescriptions were signed by the GPs before medicines were dispensed to patients.

The patients we spoke with knew how to organise repeat prescriptions. Patients talked of the website and instructions on the telephone. Staff told us that patients who were eligible to use the dispensary could chose to collect their medicines from a pharmacy of their preferred choice.

Cleanliness and infection control

The practice did not operate systems to reduce the risk and spread of infection. The practice had an infection control lead and appropriate infection control policies and procedures. The infection control policy stated that the practice would undertake an annual infection control audit and deliver infection control training to staff annually. However, an infection control audit had not been undertaken since 2011 and staff told us they had not received infection control training within the practice recommended time frame.

We observed one member of staff was not following the practice hand hygiene policy which was contained within the practice infection control file. We observed privacy curtains in two of the consulting rooms were disposable, one set had not been changed since 2008, the other set did not display a date to identify when they were last changed.

The practice had not ensured that it met the requirements outlined in Department of Health's publication, The Code of Practice for health and adult social care on the prevention and control of infections and related guidance (2009).

Hand washing guidance was available above sinks in the treatment rooms and toilets. Staff had a supply of gloves and other personal protective equipment (PPE). However, the practice did not keep a spillage kit, for dealing with bodily fluids. Staff we spoke with told us they would use gloves to clean up a spillage. This posed a risk of cross contamination.

We spoke with patients about the cleanliness of the practice. All of them told us they were happy with the environment and cleanliness.

Staffing and recruitment

GPs and nurses had a criminal records check via the Disclosure and Barring Service (DBS). Staff recruitment files contained a record of the staff member's employment history, qualifications, proof of identity and written references. These checks had been made to ensure the person being employed was of good character and had the appropriate qualifications for their role.

The practice did not use locum GPs unless they were known to the practice and had worked at the practice previously. We spoke with a locum GP who told us they were well informed by the practice, through receiving medicine and equipment alerts and attending meetings. They also told us they were able to discuss individual patients with chronic conditions with other GPs to ensure appropriate care was given.

Dealing with Emergencies

Equipment and medicines were available for use in a medical emergency. The emergency medicines, automated external defibrillator (AED) and oxygen were checked regularly to ensure they were in date and in working condition. We saw evidence of these checks. All staff had received recent basic life support training.

Are services safe?

The practice had a comprehensive business continuity plan which was reviewed annually and signed off by the senior GP partner. The practice manager had created a list of instructions for staff to follow in the event of an emergency.

Equipment

We saw records to demonstrate that practice equipment was regularly checked and maintained. For example, we saw records to confirm that medicines fridge servicing was in date and portable appliance testing [PAT] had been completed in October 2013 and was next due in October 2014. We saw records to demonstrate that fire equipment was regularly serviced.

Staff told us they had received appropriate training to use equipment safely.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

GPs told us it was their individual responsibility to keep up to date with new guidance, legislation and regulations. GPs told us they followed the relevant National Institute for Health and Care Excellence (NICE) guidelines for long term conditions management. GPs had specialist interests, for example diabetes management, and were consulted by other GPs and nurses in the practice for advice and support.

Staff told us they assessed patients' needs and planned care and treatment for patients with complex health needs. The locum GP told us they were able to discuss the background of patients with chronic problems with the practice GPs to ensure that they offered the best care and treatment. The practice were in the process of creating care plans for patients who had been identified as being at risk of admission to hospital. These care plans were to ensure that patients were supported to be safe and well at home. A GP described how they were able to access guidelines about waiting times for referrals to identify if a patient's condition fitted the criteria for an urgent referral (known as the two week wait referral).

The deputy manager told us they shared information with the Out of Hours service to ensure patients received consistent and appropriate care and treatment. For example, patients who were receiving palliative care and patients who were at risk of being admitted to hospital.

Management, monitoring and improving outcomes for people

The practice achieved high results in all domains of the Quality and Outcomes Framework (QOF) in 2012/13. The QOF was introduced in 2004 as part of the General Medical Services Contract. It is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The deputy manager described how they used data from the QOF and local enhanced services (locally commissioned health promotion services) to ensure appropriate health checks were offered to patients.

We looked at a range of clinical audits, which were held centrally on the practice intranet. Audits had been used to evaluate the effectiveness of patient treatment. An example included an audit of joint injections which had shown the treatment to be effective. We saw an example of another audit which had been undertaken to identify if published research findings for patients with deep vein thrombosis (DVT) were replicated in a patient group within the practice. The aim was to check to see if the system the practice operated meant that underlying conditions were diagnosed. The audit had identified that the practice approach to examination and diagnosis had not missed identification of underlying conditions. We were unable to evidence a quality improvement process that sought to improve patient care and outcomes through systematic review of care and the implementation of change.

The practice had a system to monitor when histology [tissue] samples had been sent for analysis. Patient blood tests results were sent to GPs for immediate action. GPs told us that blood test results were received overnight and were looked at the next morning. There was a buddy system in the practice to ensure that if a GP was not available their 'buddy' would review blood tests results as a matter of priority.

Effective Staffing, equipment and facilities

The practice had a recruitment policy and effective processes were in place to ensure patients were supported by suitably skilled, qualified and experienced staff. We were told that new members of staff spent time shadowing experienced staff until they were able to do the job. The practice manager told us they provided GPs and nurses with an introduction pack which included procedures, timetables and telephone numbers.

All staff told us they had undertaken essential training in basic life support and most staff in safeguarding of vulnerable adults and children. Continuing professional development and training was available for GPs and nurses. Staff we spoke with told us about the training they had undertaken and how they shared learning with other members of staff within the practice. The practice manager told us nurses specialised in particular care and treatment, for example, wound dressings. This enabled them to run the specialist clinic at the practice.

The practice had invested in some specialist equipment to improve diagnosis and treatment waiting times. For example, the practice had a dermatoscope (a non-invasive diagnostic equipment for the early diagnosis of skin cancer). One GP in the practice had undertaken specialist

Are services effective?

(for example, treatment is effective)

training to use the equipment and other GPs and nurses referred patients to this GP if they had any concerns about skin lesions (moles or blemishes). This internal referral system helped to identify benign (non-cancerous) lesions.

Working with other services

The practice engaged with other health and social care providers to coordinate care and meet patients' needs. Information was held on the practice intranet giving advice to staff about referrals to local support agencies and secondary care. The lead GP sometimes invited external speakers from other health and social care providers to present at lunchtime educational meetings so that staff were aware of services they could refer patients to. The practice was located in the same building as the health visitors and adjacent to the district nursing team. Staff told us they were able to communicate well with these teams to provide 'joined up' care for patients.

The GPs and nurses were involved in monthly multi-agency primary health care meetings. At these meetings staff discussed patients who were at risk. The aim of these meetings was to identify how health and social care services could work together to support patients who were at risk to remain safe and well.

A GP told us the practice did not offer drug and alcohol rehabilitation services to patients because there was a drop in facility next door and patients who required this service were directed there. A GP described how they referred patients who may be living with some form of dementia to a local memory clinic for specialist diagnosis and support.

The practice ensured correspondence from other health services was reviewed and attached to electronic patient records. There was a computer system in place to ensure GPs viewed correspondence when it was received and actions were logged and allocated to appropriate staff. We were shown this system by the deputy manager on the day of our visit.

The deputy manager told us they shared information with the Out of Hours service to ensure patients received consistent and appropriate care and treatment. For example, patients who were receiving palliative care and patients who were at risk of being admitted to hospital.

Health, promotion and prevention

The senior nurse told us the practice held various health support clinics and groups. For example, weight management and smoking cessation. The nurse told us they often referred patients to locally organised exercise programmes.

There were patient information leaflets available in the waiting room areas. These included information on hearing aid clinics, vaccine research, young person's drug and alcohol support, stop smoking advice and sexual health leaflets. The practice website contained links to a range of health promotion advice and support.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All patients we spoke with said they were happy with the care they received and felt they were safe. Patients spoke of feeling respected and being treated with courtesy. Patients told us they found the staff caring, helpful and kind. We observed staff treating patients with dignity and respect during our inspection. GPs at the practice offered patients a chaperone (another member of staff to accompany a patient) during examinations. This service was advertised in consulting rooms, however there was no information about this service available in waiting areas. We were told that chaperones were provided by nurses or health care assistants. Patients told us they were aware of the chaperone service although they had not needed to make use of the service. We saw there were screens and covers for patients to use when examinations took place. Patients were aware of the chaperone service offered at the practice.

Patients told us of staff respecting confidentiality at the reception desk. They were aware if they needed to speak in private they could ask a member of staff who would find an available room for them.

All staff at the practice were updated on any recent patient deaths. Therefore staff were aware of bereaved patients who attended the practice and could offer appropriate support. For example, contact details for the bereavement support service.

Involvement in decisions and consent

Patients told us they felt involved in their care and were able to make informed decisions. The practice had a policy on consent. We spoke with two practice nurses about the consent processes used at the practice. The nurse explained they spent time with the patient and any carer or advocate and explained the procedure that was required. If they felt the patient had capacity to consent the treatment was given, but if there were any concerns over a patient's capacity to consent they could seek advice from the GPs. A GP told us they had received training with respect of the Mental Capacity Act (2005). They described an example of where a patient had lacked capacity to consent and decisions had been made, in conjunction with other parties, in the patient's best interests. The practice had a written consent form which was completed by patients who had opted to have minor surgery at the practice. Patients we spoke with told us staff asked permission before taking blood.

GPs understood the relevance of Gillick competence (a framework for deciding whether a child is capable of consenting to care or treatment) and were able to describe an example of how they had applied the framework to make a decision about whether a child was competent to make decisions about their treatment.

We spoke with staff about the communication needs of their patients and whether any communication aids were used. We were told that repeat prescription requests from some patients who were blind were taken over the phone. Not all staff were aware of local support services which could provide translation or signing services for patients and, therefore, did not always offer these services to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its patient population group and was responsive to their needs. The GP explained to us that sometimes patients had different expectations about primary medical services. They told us they explained to patients what services were offered by primary medical services in the UK and what services patients would be referred to hospitals for. Patients told us they were able to request a male or female GP or a particular named GP if they had a special interest in a certain area of medicine. New patients registering at the practice completed a registration form that gathered comprehensive details of their health and lifestyle choices.

From our observations we saw that the premises were accessible for patients with disabilities, with seating that was accessible to patients with restricted mobility and appropriate parking spaces close to the entrance door. There was a toilet available for people with disabilities. There were arrangements to support patients with particular communication needs, for example, translation and signing services. However, not all staff were aware of these services and therefore did not always offer them to patients. There was a risk that patients who did not speak English as their first language or patients who were deaf may not receive appropriate support.

There was a range of health-related information for patients available in both the waiting room and on the practice website. For example, we found information explaining how patients could access out-of-hours care. Patients we spoke with understood where they could access advice and support when the practice was not open. However information at the front entrance to the surgery did not provide details of the Out of Hours service if patients went to the practice when it was closed. There was a risk that patients may visit the practice out of opening hours and not know where to access medical support.

The practice used a loud speaker system in the waiting area to announce when GPs and nurses were ready for their next patient. Patients told us it was difficult to hear all parts of the announcements. During the inspection we observed a number of patients could not hear the announcements, who then queued at reception to see if they had missed their appointment. The system was not effective for communicating with patients. For patients who had hearing impairments the loud speaker system posed a particular problem. We spoke to the practice about this concern. The practice manager told us that they would consider the issue and provide visual prompts for patients too.

Access to the service

All of the patients we spoke with told us it was possible to get an appointment on the same day but if they wanted to see a particular named GP they sometimes had to wait up to three weeks for an appointment. The appointment hours were between 8.50am and 12pm and 3pm and 5.50pm, Monday to Friday. GPs often conducted home visits and made telephone calls to patients between 12pm and 3pm. Staff told us that if patients felt their need to see a GP or nurse was urgent then they treated the need as urgent and arranged for the patient to see someone that day. We noted that the practice website provided patients with the opening hours of the practice but not the appointment times available.

The practice offered appointments that could be booked in advance or booked on the day. Patients could book appointments by phoning the practice or through registering for an online booking account. Patients we spoke with were positive about the introduction of the online appointment booking system. We saw that appointment booking and availability was regularly discussed at the patient participation group (PPG) meetings and the practice were looking at ways of improving patient access to appointments. The practice offered a number of bookable telephone appointments for patients who did not need to attend the practice but wanted to speak with a GP instead.

We reviewed the results of the 2013/14 national GP survery. We noted that 88% (110) of patients were able to get an appointment to see or speak to someone the last time they tried. Over 93% (117) of patients said the last appointment they got was convenient to them. In addition, 84% (105) of patients described their overall experience of this practice as good.

Concerns and complaints

Some patients we spoke with did not know how to make a complaint. We noted there was a notice in the waiting area informing patients how to complain but it had out of date information about organisations patients could contact if they did not want to complaint to the practice. Patients we spoke with told us they were satisfied with the service and

Are services responsive to people's needs?

(for example, to feedback?)

did not have any reason to complain. We looked at the practice's complaints and significant events records. We saw the practice had a clear process to register patient complaints, analyse, review and record the complaints. We saw patients had been contacted either in writing or by telephone to explain the outcome of their complaint. One example of a complaint we noted was when a patient had been given two flu vaccinations, one by the practice and one by the district nurse. We saw the practice had investigated the complaint, found out why the error had occurred, written and explained to the patient concerned and put preventative actions in place to ensure the error was not repeated. The complaint had been fully discussed at the practice primary health care team meeting and a significant event log sheet completed.

The practice had a patient participation group (PPG). A PPG is a group of patients registered with the practice who have an interest in the services provided. The aim of the PPG is to represent patient views, to work in partnership with the practice, and to improve the services for patients. The practice undertook a regular patient satisfaction survey and reviewed comments left on the NHS choices website. We saw examples of improvements the practice had made as a result of the patient survey. One of these examples included the introduction of an online appointment booking for patients. The practice also held a staff meeting to identify ways to improve patient care following feedback which had been left on the NHS choices website. We were told that additional staff training was planned to support staff with providing better customer care for patients.

Are services well-led?

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

Our findings

Leadership and culture

We spoke with staff about the ethos of the organisation. They consistently told us their focus was to provide a helpful and effective service to patients. Staff told us the GPs were conscientious and worked very hard to provide quality care. The majority of staff told us the practice had an open culture and felt able to raise any concerns or suggestions for changes with the partner GPs or practice manager.

We spoke with the practice manager and partner GPs about the future vision and strategy for the practice. We were told that this was discussed at meetings attended by the GP partners and practice manager. We were provided with examples of how the practice was preparing for the future. However, not all staff were aware of this.

Governance arrangements

Quality and performance were monitored by the practice. The Quality and Outcomes framework (QOF) was used to monitor the effectiveness of the service. Some GPs had specific areas of responsibility, such as the dispensary, oversight of complaints, or safeguarding. Other GPs had areas of specialist interest, such as diabetes, minor surgery and palliative care. The GPs all felt they had a collective responsibility for making decisions and monitoring the effectiveness of clinical practice and they were supported in this role by the deputy manager and practice manager. The practice had leads in nursing and business roles with designated responsibilities. Most of the policies and procedures we reviewed were in date and had been reviewed.

Systems to monitor and improve quality and improvement

The practice used available data to identify areas for improvement. The deputy manager held regular QOF meetings with GPs and nurses and identified areas for change. We found that the practice achieved high scores in the Quality and Outcome Frameworks audits (QOF), which meant that the practice provided patient outcomes which compared favourably to other GP practices.

We looked at prescribing reports from 2013 and 2014. The reports showed that the practice had taken steps to standardise their prescribing in line with local guidelines.

The practice conducted clinical audits to monitor and improve patient care. We looked at an example of an audit of heart failure conducted during 2012 and 2013. The audit identified areas for improvement. Whilst we saw evidence of clinical audit we did not see records to demonstrate that clinical audits had been repeated to ensure improvements were made.

The practice participated in the dispensing service quality scheme (DSQS) and submitted data on an annual basis so that the quality of the dispensing service was monitored. The results we saw demonstrated that the practice operated a dispensing service which had been improved where opportunities were identified.

There was no system in place to report back to the practice manager the results of the safety checks which had been prompted by medicines and equipment alerts.

Patient experience and involvement

The practice held regular patient participation group (PPG) meetings which were attended by both the practice manager and a GP. The PPG produced an annual report. The most recent report highlighted the results of the patient survey and identified actions.

The practice had a complaints policy. Where a formal complaint was made it was resolved in line with the practice procedure. The practice responded to some comments left on the NHS choices website. The practice reflected on the comments and the results of the NHS GP survey to improve patient care and treatment.

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

Staff told us the practice had an open culture. Most staff felt able to raise any concerns and were confident that these would be listened to and acted upon. There were a range of meetings held across the practice. For example, the lead nurse held nurse meetings to share learning and best practice. The reception and administration staff had ad hoc meetings to discuss changes as they arose. There was no system to seek the views of staff to ensure their views were taken into account when assessing the standard of care and treatment the practice provided. Some staff we spoke with felt it would be useful to have more regular meetings so that they understood the practice's long term vision and were able to contribute towards it.

Are services well-led?

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

Management lead through learning and improvement

The practice was a GP training practice (GPs worked within the practice as part of their professional training). We received mixed feedback from staff about learning and development within the practice. Some staff felt the practice did not have an ethos of continual learning and development due to workload and time constraints. Other staff told us they were always supported to attend relevant training to ensure their clinical skills were updated. The senior GP partner agreed that the focus on learning and development had slipped over the last couple of years due to time constraints.

Staff within the practice received an annual appraisal. Staff we spoke with were positive about the appraisal system and told us they were able to raise any concerns and discuss their own development. The practice manager showed us forms which were used to gather evidence before and during the appraisals. Appraisal records were brief, containing three lines about issues raised during the meeting and three lines about actions agreed.

The practice manager and GP attended monthly 'locality meetings' with other local GP practices. They told us this enabled problems and good practice to be shared and discussed with practices across the clinical commissioning group area.

Identification and management of risk

The practice manager told us the practice held a risk register. The practice had a comprehensive business continuity plan which would enable the practice to maintain a service in the event of an emergency. This plan was regularly reviewed and signed off by the senior GP partner.

GP partners and the practice manager regularly met to discuss the future vision of the practice and how to improve services. The practice met with other GPs in the locality area to discuss the future provision of GP services across the area and to identify areas where practices could work together to improve services for patients.

Older people

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

Our findings

The practice had a system to ensure every patient aged 75 years and above had a named GP. There was a system in place to ensure that patients turning 75 were sent a letter confirming who their named GP was. Patients we spoke with who had a named GP told us this was beneficial for their health and wellbeing.

The practice had close working relationships with the community nursing team. Staff told us they received regular updates from the community nurses regarding care of elderly patients in their own homes. The practice ensured that elderly patients who were unable to visit the practice received appropriate care and treatment. GPs conducted home visits to patients in their own homes or in local nursing homes.

The practice had started to identify and review patients who were at risk of being admitted to hospital and were in the process of creating care plans for these patients to ensure that they were appropriately supported by a range of health and social care providers.

A GP took a lead role for palliative care. We were told that since this GP has assumed the lead role the number of patients who had been able to remain in their own home to die had increased. The practice reviewed a list of patient deaths at their regular meetings and looked at whether deaths had occurred in the patient's location of choice. If they had not, the practice looked at what could have been done differently

People with long term conditions

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

Our findings

We spoke with five patients with long term conditions who were pleased with the service they received. The majority of these patients told us they required regular monthly treatments, blood tests and examinations and considered themselves to be very well looked after by all the GPs, nurses and reception staff. They told us they felt fully involved in their care and treatment and were treated with respect and always felt they were listened to.

Nurses attended training in relation to the specialist long term condition clinics they offered. This enabled them to provide patients with up-to-date information about their condition and their medicines. We were told that nurses would attend patients at home to undertake reviews of the patient's long term condition if the patient was not able to attend the practice.

The practice had identified nurse and GP leads for some long term conditions. For example, diabetes and asthma. The GPs and nurses who held these lead roles were supported with training and development. Staff told us they felt diabetes management was one of their strengths. The lead GP provided GPs and nurses with information and support with managing patients' diabetes. We were told that patients who were newly diagnosed with diabetes were referred to a local support group who provided support for diet and exercise.

The practice ran clinics for patients with asthma, diabetes, heart disease and for patients who had a stroke. These clinics were delivered by the practice nurses who had undertaken specialist training. The GPs told us there were a variety of community specialist nurses for long terms conditions, to whom they could refer patients for additional support and treatment. Examples included diabetes, neurology and tissue viability.

Mothers, babies, children and young people

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

Our findings

Staff had training in relation to safeguarding of children and knew how to identify and report suspected abuse. The practice had effective working relationships with local health visitors and held meetings to discuss children who were at risk. The lead nurse and deputy manager had a lead role for child immunisations and highlighted any concerns to the health visitor if there was non-attendance for immunisations. The practice record system highlighted children who were on a child protection plan. Vulnerable children were discussed at regular multi-agency meetings.

Patients requiring a first antenatal appointment were offered an appointment with the nurse immediately followed by an appointment with the GP. The practice worked closely with community midwives who saw patients at the practice. GPs offered six week post natal checks for new babies. The practice held regular child immunisation clinics. Health visitors also held child health clinics within the practice and worked closely with the GPs if they had any concerns about a child's health.

A GP explained to us an example of how they had assessed a child's competency to provide consent to treatment. The explanation demonstrated an awareness of the legal framework for obtaining consent and 'Gillick competence'.

Staff told us they would always see parents and children if a parent called with concerns about their child's health. Parents we spoke with told us the practice had responded immediately if their children had been ill and they had been able to see a GP straight away.

Working age people (and those recently retired)

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

Our findings

The practice did not offer any evening or weekend appointments to improve access for the working age patient population. Patients of working age told us they preferred to take the early appointment (8.50am) so that it did not affect their working day too much. Patients told us they had used the online booking system and found it to be very easy to use and effective. They told us they were able to make an appointment at a time to suit them. The practice offered telephone appointments. The practice operated a repeat prescription service so that patients did not have to attend for an appointment only to obtain a prescription.

Patients of working age told us they did not have any specific problems with getting an appointment but they did prefer to take the early appointment (8.50am) so it did not affect their working day too much. We found the practice did not offer any evening or weekend appointments for patients.

The practice offered general health checks to patients. A practice nurse ran weight management clinics and referred patients who wanted assistance with managing their weight to the Oxfordshire Weight Loss (OWL) service.

The lead GP had recently invited a gastric surgeon to speak at a practice lunch meeting to educate GPs and nurses about surgery and the best time to refer patients to a consultant for the most effective outcome.

Some clinical audits informed care and treatment for the working age population.

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

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

Our findings

The practice had a system to identify patients who had caring responsibilities. These patients were offered flu vaccinations. Caring responsibilities were noted on patients' records, so that if a carer was admitted to hospital the GP would be aware that there was a person at home who required support. Staff told us they signposted carers to the local carers centre for support. The practice also utilised funding for 'carers breaks', which they could offer to seven patients every year. We were told the practice always used the funding on offer.

The practice had a system in place to identify patients with a learning disability and to ensure GPs arranged annual health checks for these patients. The GPs used a nationally recognised template to ensure comprehensive health checks were undertaken.

We spoke with reception staff about patients who did not have a fixed address within the practice local area. Staff told us that if these patients attended the practice they would be seen as a temporary patient. We asked staff about preventative care, such as smear tests and child immunisations, for patients with no fixed address. Staff told us that if patients did not have an address to send a smear result to, they would not offer a smear test. However, if a child's 'red book' (health record) was available they would provide child immunisations.

A GP told us the practice did not offer drug and alcohol rehabilitation services to patients because there was a drop in facility next door.

The practice offered a chlamydia screening service and patients with sexual health concerns were signposted to the local sexual health service.

People experiencing poor mental health

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

Our findings

Staff told us they had received training at a recent meeting about the services that MIND (a mental health charity) could offer to support patients. The lead GP was able to give an example of how they had worked closely with the local mental health services to support a patient who was experiencing poor mental health and to ensure that decisions about care and treatment were made in the patient's best interests. The explanation they gave showed they had acted in accordance with the Mental Capacity Act (2005).

A counsellor visited the practice one day a week and provided appointments for patients who were referred by the GPs.

The GPs told us they met with psychiatrists of patients who they were jointly responsible for care. This enabled the GPs to discuss concerns and identify any patients who had not attended for regular health reviews to ensure that appropriate support was offered to these patients.

A GP described how they referred patients who may be living with some form of dementia to a local memory clinic for specialist diagnosis and support.

The practice appointment system offered an accessible service for patients experiencing varying mental health problems and for those who required flexibility.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Patients who used services, staff and others were not protected against identifiable risks of acquiring infection by the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of healthcare associated infection. Regulation 12 (1) (a)(b)(c) (2) (a)**