Westongrove Partnership - Wendover Health Centre

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Overall summary

This practice is rated as Good overall.

The previous inspection was in December 2014 and the practice was rated Good.

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Westongrove Partnership – Wendover Health Centre in Buckinghamshire on 23 April 2018. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

At this inspection we found:

- The practice had comprehensive systems in place to manage and monitor risks to patients, staff and visitors. This included risks to the building, environment, medicines management, staffing, equipment and a range of emergencies that might affect operation.
- Patient outcomes and information collected for the Quality Outcome Framework (QOF), the local performance scheme (known as Primary Care Development Scheme) and performance compared to national screening programmes was high.
- The practice routinely reviewed the quality and effectiveness of the care it provided. Care and treatment was delivered according to evidence based guidelines. We saw that a wide range of clinical audits were carried out and there was a whole practice approach to improvement.
- The leadership, governance and culture were used to drive and improve the delivery of its service. All staff were involved in the development of the practice and were proud of their achievements.
- The practice reviewed the needs of their local population and had initiated positive services for patients.
- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility and choice.
- There was a strong focus on education, continuous learning and improvements at all levels in the practice. When incidents did happen, the practice learned from them and improved their processes.
- There was evidence that service improvement was a priority among staff and leaders. High standards were promoted by all practice staff and there was strong team working and a commitment to personal and professional development.

We saw several areas of outstanding practice:

- The practice leadership was committed to meeting the needs of its population. This was evidenced through themed and targeted services, clinical audits and health promotion. This included a range of initiatives to meet the needs of specific groups – for example older people and people with dementia.
- The practice was aware of an increasing elderly population within the community. This led to the development of a service specifically for older people; this service was known as The Weston Service. The focus was to support patients (aged over 75) and their carers with a GP led nurse team to oversee and co-ordinate health and social needs. We saw the practice reviewed and audited the efficiency of the service; we saw recent data which indicated the service had 70 new cases and reduced hospital admissions by 33% (101 avoided admissions). The service and the impact on patients have been recognised both locally and nationally. For example, the project won an innovation award from the Queen's Nursing Institute (a nationally recognised award celebrating innovation and commitment to patient care and nursing practice) and Bucks County Council Dignity and Respect awards.
- There was clear, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver sustainable care. There were deeply embedded systems of leadership which aimed to ensure that senior staff had considered the needs for the future.

Overall summary

There was an area where the provider should make improvements:

- Consider the implementation of a hearing loop system at all three sites to support patients with impaired hearing.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector; the team included a GP specialist adviser.

Background to Westongrove Partnership - Wendover Health Centre

Westongrove Partnership – Wendover Health Centre in Buckinghamshire provides primary medical services to the population of Wendover, Bedgrove, Aston Clinton and surrounding smaller villages. The practice is a semi-rural training practice within Buckinghamshire Clinical Commissioning Group (CCG) and provides primary medical services to approximately 28,600 registered patients.

Services are provided from three different locations:

- The Health Centre, Aylesbury Road, Wendover, Buckinghamshire HP22 6LD
- Bedgrove Surgery, Brentwood Way, Bedgrove, Buckinghamshire HP21 7TL
- Aston Clinton Surgery, 136 London Road, Aston Clinton, Buckinghamshire HP22 5LB

The practice website is:

- www.westongrove.com

During the April 2018 inspection we visited the main practice in Wendover and also one of the branch practices, Bedgrove Surgery.

According to data from the Office for National Statistics, Buckinghamshire, specifically the Wendover, Bedgrove and Aston Clinton areas have high levels of affluence, low levels of deprivation and little ethnic diversity. The practice population has a significantly higher proportion of patients aged over 60 when compared to the local CCG and national averages. The practice also provides primary care GP services for 11 local care and nursing homes (approximately 400 patients) within the local area.

Care and treatment is delivered by nine GP Partners, 14 Salaried GPs, a paramedic, a pharmacist, three nurse team leaders and a team of practice nurses and health care assistants. One of the GPs is the designated dispensary lead and the dispensary team consists of three dispensers and two dispensary assistants.

A Senior Management Team consisting of a GP Partner, Operations and Development Manager and Human Resources and Finance Manager oversee three site managers. The management team are supported by a team of reception, administrative and secretarial staff who undertake the day to day management and running of Westongrove Partnership.

The practice is a training practice for GP Registrars and Medical Students. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

One of the practices (Wendover Health Centre) was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy.

The practice has core opening hours between 8.30am and 6.30pm every weekday. There is a range of extended hours available.

- Wendover Health Centre – Early morning appointments are available with appointments starting at 7.30am, Monday to Friday. Evening appointments are available every Tuesday evening until 8pm and weekend appointments are available on Saturday mornings between 8.15am and 11.30am.
- Bedgrove Surgery – Early morning appointments are available with appointments starting at 8am, Monday to Friday. Evening appointments are available every Wednesday evening until 8.30pm.
- Aston Clinton Surgery – Early morning appointments are available with appointments starting at 8am, Monday to Thursday and 7.30am each Friday. Evening appointments are available every Wednesday evening until 8pm.

The dispensary has core opening hours between 8.30am and 6.30pm every weekday. Extended dispensary hours were available on Tuesdays between 8am and 8pm and Saturday mornings between 9am and 11am.

Out of hours care is accessed by contacting NHS 111.

The practice is registered by the Care Quality Commission to carry out the following regulated activities: Maternity and midwifery services, Family planning services, Treatment of disease, disorder or injury, Surgical procedures and Diagnostic and screening procedures.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. All staff we spoke with discussed key elements of safeguarding appropriate to the population the practice served, for example, the practice population had a significantly higher proportion of patients aged over 60, staff described how to identify and report concerns including concerns such as abuse and neglect. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The Human Resources and Finance Manager managed the recruitment processes which included completion of appropriate staff checks at the time of recruitment and on an ongoing basis. This included details of professional registration where appropriate.
- There was an effective system to manage infection prevention and control. Infection prevention control across the three different locations was managed by one of the practice nurses, who worked collaboratively with the Infection Prevention Control Lead from the clinical commissioning group. Annual infection control audits were carried out and we saw evidence the findings of the audits had been discussed.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were appropriate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The provision of services across three different locations enabled patients to be seen at any of the three practices and provided flexibility and resilience for staff absence.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. One of the significant events we reviewed detailed the practices' positive response following a medical emergency within the local community.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. We saw the practice held appropriate equipment including non-invasive fingertip pulse oximeter for adults and children to monitor symptoms of potential medical emergencies.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols. The practice used a directory of local guidelines to

facilitate referrals through pathways. This provided comprehensive, evidence based local guidance and clinical decision support at the point of care and was effective in reducing referrals.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. We saw patient literature in the waiting areas which clearly explained safe and appropriate antibiotic usage.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Arrangements for dispensing medicines at the practice kept patients safe.
- The practice had a designated GP lead for the dispensary. The dispensary had documented processes which they referred to as standard operating procedures (SOPs). All staff involved in the procedure had signed, read and understood the SOPs and agreed to act in accordance with its requirements. SOPs covered all aspects of work undertaken in the dispensary. The SOPs we saw would satisfy the requirements of the Dispensary Services Quality Scheme (DSQS). The SOPs had been reviewed and updated in the last 12 months and there was a written audit trail of amendments.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. The Operations and Development Manager, Pharmacist and Site Managers received the safety alerts, reviewed the details of the alerts and if required shared the required actions to the relevant members of staff including the dispensary. When alerts concerned medicines the relevant clinician or the pharmacist carried out patient searches to determine whether there were any potential risks to patients.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and the population groups as good for providing effective services overall except for the Older People population group which we rated Outstanding.

The Older People population group was rated outstanding for effective because:

- The practice had implemented an initiative for older people to support their health needs, which had reduced hospital admissions by 33%.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used mobile information technology to improve and coordinate treatment. For example, the designated GPs for the care and nursing homes used mobile information technology systems for quick and easy access to real-time patient information. This enabled the team to make effective and safe decisions at the point of care, including mobile access to patients' medical records and supporting documents such as x-rays and test results.
- Clinicians attended local education events to improve practice in relation to new guidance and standards.
- The practice was prescribing hypnotics, antibacterial prescription items and antibiotic items including Cephalosporins and Quinolones in line with local and national averages.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice was aware of an increasing elderly population within the community. This led to the development of a service specifically for older people; this service was known as The Weston Service. The focus was to support patients (aged over 75) and their carers with a GP led nurse team to oversee and co-ordinate their health and social needs. We saw the practice reviewed and audited the efficiency of the service; we saw recent data which indicated the service had 70 new cases and reduced hospital admissions by 33% (101 avoided admissions). The service and the impact on patients have been recognised both locally and nationally. For example, the project won an innovation award from the Queen's Nursing Institute (a nationally recognised award celebrating innovation and commitment to patient care and nursing practice) and Bucks County Council Dignity and Respect awards.
- One of the GPs was the Lead GP for frailty within older patients. The practice used guidance from The British Geriatric Society and leading charities to amend a national tool to identify patients aged 65 and over who were living with moderate or severe frailty. This included case finding, assessment and care management. Those identified as being frail had a clinical review including a review of medicines and were referred to appropriate support via The Weston Service.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older patients were higher when compared with local and national averages. For example, performance for osteoporosis (osteoporosis is a condition that weakens bones, making them fragile and more likely to break) indicators were higher than both the local and national averages. The practice had achieved 100% of targets which was higher when compared to the CCG average (93%) and the national average (91%).
- Patients aged over 75 were invited for a health assessment. The assessments, if appropriate were completed by The Weston Service and if necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.

Good

Are services effective?

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. For example, clinicians had the skills and experience to complete comprehensive geriatric assessments and manage patients with frailty and complex health and social needs.

People with long-term conditions:

- The practice provided co-ordinated reviews of individual patient's health and long term condition needs. This reduced the burden of appointments for patients and facilitated a holistic approach to care. For patients with the most complex needs there was a facility both through the practice website and dispensary to ensure repeat medicines quantities and durations were synchronised. This further reduced the burden for patients and reduced the risk of medicines being stockpiled or missed.
- There was a central admin team who managed and scheduled the recall programme for patients with long term conditions. The team worked alongside designated clinical lead members of staff who were responsible for completing the reviews. We saw all the specialist nurses for example; diabetes nurses, asthma nurses and leg ulcer nurses all had received specific training for their role.
- GPs followed up patients who had received treatment in hospital or through out of hours services.
- Performance for long term condition related indicators showed the practice was in line and above local and national clinical targets. For example, 100% of diabetes targets had been achieved which was higher when compared to the CCG average (92%) and the national average (91%).

Families, children and young people:

- Childhood immunisation rates for the vaccinations given were higher when compared to the national averages. For children under two years of age, four immunisations are measured; each has a target of 90%. The practice achieved the target in all four areas; in three of the four areas the practice scored over 95%. Similarly, immunisation data for children aged five, was higher than national averages.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance. The practice hosted weekly baby clinics at two of the three sites.

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

- The practice's uptake for cervical screening was 80%, which was in line with the 80% coverage target for the national screening programme. Staff were made aware of inadequate smears and provided with any supervision requirements.
- The practices' uptake for breast and bowel cancer screening was higher when compared to the local CCG average and national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Health checks were available at all three sites and at varying times throughout the week to increase participation. In the last 12 months, 1,788 invites had been sent and 645 health checks had been completed. We saw there was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. For example, one recent health check highlighted raised cholesterol in a patient. This was then referred onto a GP to discuss lifestyle changes, such as taking regular exercise to help lower the cholesterol.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Good

Are services effective?

- The practice held a register of patients living in vulnerable circumstances including homeless people, those at risk of rural isolation, travellers and those with a learning disability. The practice assisted and provided GP services for transient patients including homeless and members of the nearby canal community.
- There were 75 patients on the Learning Disabilities register; all 75 had been invited for an annual health check. We saw 65 of the 75 (87%) had attended a health check, and the remaining 10 patients had been contacted on the telephone on further occasions inviting them to attend a health check.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- 92% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher when compared to the local CCG average and the national average.
- 99% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher when compared to the local CCG average and the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 97% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was above the local CCG average (88%) and the national average (91%).
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice had recently launched the 'The Herbert Protocol'. This was an initiative introduced by national and local police forces, the Alzheimer's Society, health trusts and Dementia Action Alliances to provide police officers with early access to information when dealing with missing people living with dementia. Information and the required paperwork was available in the practice and on the website. The practice had started to encourage patients living with dementia and their carers to complete the form which was designed to make sure that, if someone was reported missing, the police could access important information about that person as soon as possible. The form contained information about their medical status, mobility, access to transport, places of interest and daily routines. Once completed, copies were made and then available for use if the person should ever be reported missing.

Monitoring care and treatment

As a training practice, the practice had a long tradition of using evidence-based techniques to support the delivery of high-quality care; we saw all staff were actively engaged in activities to monitor and improve quality and outcomes.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits. We reviewed a two cycle audit concerning the practice population who had atrial fibrillation to ensure they were on appropriate treatment. (Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate). The second cycle of the audit highlighted more patients were now receiving appropriate treatment.

We saw opportunities to participate in benchmarking, peer review and accreditation were pursued and staff spoke positively about the culture in the practice around quality improvement.

The practice used the information collected for the Quality Outcome Framework (QOF), local performance scheme (known as Primary Care Development Scheme) and performance against national screening programmes to

monitor outcomes for patients. The QOF incentive scheme rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice used the electronic system to alert clinical staff to collect QOF data when patients attended for a consultation or a home visit was carried out.

- The most recent published Quality Outcome Framework (QOF) results showed 100% of the total number of points available had been achieved, compared with the CCG average (96%) and the national average (98%).
- The exception reporting rate was 6% compared with the CCG average (4%) and the national average (6%). Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).
- The practice was working with the CCG and introduced a care and support approach, known as PCDS, for the care of many long term conditions and was a significant shift away from QOF reporting. We saw the PCDS performance data for March 2018 showed (with four weeks left to collect and cleanse data) the practice was above many targets and on track to achieve the other remaining targets.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. The continued development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. One of the nurses was a cervical screening mentor and facilitated and supported best practice in relation to the practical elements of the cervical screening training programme in order to assess and determine competence in novice sample takers.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff told us they were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice told us they had recently implemented a new appraisal system following staff feedback. We spoke with the Human Resources and Finance Manager who discussed the new feedback tool with a view to help individuals identify where their strengths and development needs lie. The new process included getting confidential feedback from line managers, peers and direct reports (if applicable). During the transitional period between appraisal systems, the practice continued to review learning and development needs through meetings and discussions.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. We spoke with management team who had records to demonstrate that the dispensers' competence had been checked regularly. When we spoke with the dispensary staff they were aware that their competence had been checked since they obtained their qualifications.
- The practice participated in the Dispensary Services Quality Scheme (DSQS). All dispensers were trained to NVQ level 2 and had a minimum of 1000 hours experience in accordance with the requirements of this scheme.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.

Good

Are services effective?

- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received co-ordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Where appropriate the practice referred patients to the multidisciplinary assessment service (MuDAS). MuDAS provides GPs with access to specialist medical staff to support patients to stay at home and avoid being admitted to hospital. We saw the practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The Weston Service had piloted mobile technology when in patient's homes including a mobile printer. As a result all patients had a personalised folder containing their medical record, list of important contact numbers and a clear personal plan of their wishes should their condition deteriorate. This record was integrated into their GP record and also put on the Bucks Co-ordinated Care Record. The Bucks Co-ordinated Care record (BCCR) is an electronic record, which enables patients to record their wishes and preferences about their care.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health and well-being, for example, stop smoking campaigns, sun protection, hay fever and tackling obesity. During the inspection, clinical members of staff described referrals they had made to a local service to help patients lose weight, quit smoking, get more active, feel happier or manage their long term condition.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Verbal and written feedback from patients was positive about the way staff treat people.
- Feedback from external stakeholders which accessed GP services from the practice was positive.
- Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable with others both locally and nationally for its satisfaction scores on consultations with GPs and nurses.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- All but two of the 84 patient Care Quality Commission comment cards we received were positive about the service experienced at the practice. There were two negative comments but no themes emerged from this feedback.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (AIS), a requirement to make sure that patients and their carers can access and understand the information that they are given. Further information about the AIS was available in the practice and on the practice website. Practice staff and new patient registration forms encouraged patients to highlight communication or information support needs.

- Staff communicated with people in a way that they could understand, for example, translation services and easy read materials were available. However, communication aids for patients with hearing impairments were limited; for example, a hearing loop was not available at any of the three sites.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them. This included work with an independent local charity which supported unpaid, family carers in Buckinghamshire.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception and dispensary staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice and the population groups as good for providing responsive services overall except for the Older People population group which we rated Outstanding.

The Older People population group was rated outstanding for responsive because:

- The practice was committed to meeting the needs of its population. This was evidenced through responsive services to meet the needs of an increasing elderly population within the community. This led to the development of a service specifically for older people; this service was known as The Weston Service.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations and a range of extended hour appointments were available which supported patients who were unable to attend the practice during normal working hours.
- All the facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. This work was predominately carried out by the service specifically for older people; this service was known as The Weston Service. Staff described how they supported patients to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice provided dispensary services for people who needed additional support with their medicines, for example, weekly or monthly blister packs.

Older people:

- Patients aged 75+ had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- There was a daily prescription delivery service, run by one of the patient groups within the practice. The practice had well established governance and management arrangements in place to ensure the safe and effective running of the service. The practice was aware of an increasing elderly population within the community and many patients lived in isolated areas, without access to public transport. We saw and spoke with a number of volunteers who delivered medicines to patients at their homes.
- A number of older patients and those living in rural communities relied on a local voluntary transport service ran by one of the patient groups, to bring them to and from the practice. The practice operated a flexible appointment system to accommodate these patients and fit in with the times the transport service (a service which the practice actively supported) could get them to and from their appointments.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs, nursing team and paramedic also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice provided GP services to 11 local care and nursing homes for older people. There were designated GP points of contacts for the homes (supporting approximately 400 patients). Contact details of the designated GPs were shared with the relevant staff, enabling continuity of care and quick access to the right staff at the practice. The designated GPs held regular visits to the homes and also provided appointments on an ad-hoc basis. We spoke with the representatives from three of the homes; they advised the practice was highly responsive. Regular meetings were held at the care and nursing homes with the focus of the meetings to support and educate to ensure the most appropriate care pathway was followed to ensure the best outcomes for patients.

People with long-term conditions:

- There were comprehensive arrangements in place to encourage patients with long term conditions to attend

for their review appointments. Administrative staff and the nursing team worked closely together. Each month a list of patients for review was prepared, a nurse reviewed and noted the type and length of appointment needed. Administrative staff then made the arrangements to book patients in for personalised appointments. This meant multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.

- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice provided an anti-coagulation clinic for patients receiving a medicine used in the prevention of blood clots. At the time of our inspection, 375 patients accessed this clinic.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- There was a daily children's clinic, therefore all parents or guardians calling with concerns about a child under the age of 16 were offered a same day appointment when necessary. On average, the children's clinic saw 12 patients a day. The practice had recently reviewed the variety of presenting symptoms at the children's clinic. Evidence suggests the vast majority of these patients would have attended less appropriate health services such as the local hospital if they had not been able to be seen by the practice.
- The practice offered a full range of contraceptive services including long acting devices.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, early morning appointments, evening appointments, Saturday appointments and a range of services at each of the three sites.
- The practice offered a full range of health promotion and screening which reflected the needs for this age group. Patients could order repeat prescriptions and book appointments on-line.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice worked alongside the local health visiting team and engaged with a travelling community who accessed GP services from the practice. The practice visited the community with a view to improve communication, and specifically reviewed registration details. The practice told us this was also an opportunity to highlight the importance of childhood immunisations, health recall and screening programmes. Furthermore, we saw the practice recognised that some of these patients had literacy difficulties and verbal communication was used to support these patients' access services.
- The practice had identified that there were a number of military veterans in their patient population and had taken action to help ensure this group of patients received suitable support in line with the government's armed forces covenant. The practice encouraged these patients to identify themselves through signage at the practice, military veteran information packs, information on the practice website and via questions on the 'new patient' form. As a result of the increased awareness of the armed forces covenant, there had been a significant increase in the number of patients on the military veteran register; at the time of our inspection 270 patients were on the register.

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

- The practice offered flexible longer appointments for patients with complex mental health needs.
- The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Care plans were in place for patients with dementia.

Good

Are services responsive to people's needs?

- The practice was a member of local and national dementia groups, these alliances enabled the practice to share best practice and ensure people with dementia received a responsive service. For example, staff had a good understanding of how to support patients with dementia. The majority of staff had additional training in recognising and supporting people with dementia. Furthermore, the practice had implemented a project to support emergency services when dealing with missing people living with dementia.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use. Written feedback we received also highlighted responsiveness of the children's clinic and express clinics for on the day concerns.
- We saw the practice reviewed the responsiveness and access to The Weston Service at regular intervals. The findings from these reviews indicated high levels of patient, carer and refer (usually the GP) satisfaction in terms of the access to the designated team and support available.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff supported and encouraged patients to provide feedback.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. One of the complaints we reviewed indicated a diagnosis had been missed. We saw the complaint was handled in line with the complaints procedure and then the complaint was also reviewed using the in house significant event tool to ensure all learning was captured and disseminated to all staff.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as Outstanding for providing a well-led service.

The practice was rated as outstanding for well-led because:

- The practice leadership was committed to meeting the needs of its population. This was evidenced through themed and targeted services, clinical audits and health promotion. This included a range of initiatives to meet the needs of specific groups – for example older people and people with dementia.
- There was clear, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver sustainable care. There were deeply embedded systems of leadership which aimed to ensure that senior staff had considered the needs for the future.

Leadership capacity and capability

- The leadership team had the capacity and skills to run the multi-site practice and ensure high quality care. They prioritised safe, high quality and compassionate care. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. The GP Partners and leadership team were visible across all three sites practice and staff told us that they were approachable and always took the time to listen to all members of staff.
- The leadership team were knowledgeable about issues and priorities relating to the quality and future of primary care services. They understood local and national challenges and were addressing them.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. Staff had attended various management and leadership courses, one recent course was a course titled “Lead, Manage and Thrive”. A course designed to improve resilience within a changing complex primary care system.
- The practice had reviewed the management and supporting processes and implemented a non-traditional, yet clear management model which created consistency across all three sites with senior management team oversight. The management structure was regularly reviewed and updated, including the management and skill sets of the nursing teams to tailor services more effectively for patients across all sites.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. The practice worked with the local clinical commissioning group (CCG) and other GP practices in the locality to develop shared sustainable services.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The strategy and objectives were challenging and innovative, whilst remaining achievable and focused on ensuring patients’ needs were met. In particular those patients in vulnerable groups including patients over 75, which aligned to the changing demographics within the patient population. We saw another key component within the vision was improving the work life of practice staff including support and development.
- The strategy was in line with health and social priorities across the local community. The practice planned its services to meet the needs of the practice population.
- The practice captured and monitored progress against delivery of the strategy through annual reports and a live document known as the high impact action plan.
- The practice developed its vision, values and strategy jointly with patient groups, staff and external partners.
- Staff were aware of and understood the vision, values and strategy. Their role in achieving them was discussed in team meetings, staff newsletters and staff communication boards. Staff told us the practice vision and values were embedded into meetings and everyday activities within the practice.

Culture

The practice had a culture of high-quality sustainable care.

- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.
- There were high levels of satisfaction across all staff. Staff stated they felt respected, supported and valued. We received written and verbal feedback from staff

which indicated high levels of job satisfaction. All staff told us they were proud to work in the practice. The practice was a GP training practice; we received extensive written feedback from one of the GP Registrars who spoke of the quality of culture, leadership and support received at the practice. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. Furthermore, we spoke with a recently recruited member of staff who praised the culture of the practice.

- Throughout the inspection, staff consistently told us that they were listened to and supported to develop. For example, the practice had implemented two monthly staff awards, one award for 'hero of the month' and one award for 'best new idea'. Social events were regularly organised to promote team building and cross site working was in place for all staff.
- The practice focused on the needs of patients. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and patients' experiences. For example, The Weston Service (a service specifically for older people) visited for immediate health problems, but also assessed holistic needs of patients and assisted them with accessing support for social needs.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. The practice had appointed a designated Freedom to Speak Up Guardian as part of their commitment to deal with concerns openly, responsibly and professionally.
- There were processes for providing all staff with the development they need. This included role specific training and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- All staff, including the nursing team and dispensary team, were considered valued members of the practice team. Clinical staff were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. For example, there had been a recent all practice training session which focused on resilience, well-being and mindfulness.
- The practice actively promoted equality and diversity. Staff felt they were treated equally.
- Despite services being provided across three sites, we saw there were positive relationships between all staff, all teams and all sites, the leaders promoted a culture of one team.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance. These arrangements were proactively reviewed and reflected best practice.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. There was an overarching five year business plan, a 10 point high impact action plan which covered all aspects of the service provided, including improving the health of the population, reducing the cost of healthcare, staff education and site development. We also saw plans which reviewed frequency of and themes of audits; reviewed workflow optimisation and monitoring of national and local quality schemes for example, the Quality and Outcomes Framework. All plans were regularly reviewed to ensure outcomes were achieved or adapted accordingly. This was evidenced in minutes of meetings and discussion with all members of staff.
- There was a senior management team in place to oversee the systems, ensuring they were consistent and effective. Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Are services well-led?

- The practice had implemented standard operating procedures and protocols at the main location and all the branch sites to promote consistency.

Managing risks, issues and performance

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.

- The practice had processes and plans to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. The senior management team had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. The audit programme was designed and themed to reflect and review the specific needs of the population to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. Plans and documents were live and fluid to address any identified weaknesses and changes.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Data protection training occurred internally for most staff and the senior management team had undertaken additional reading in line with the implementation of the General Data Protection Regulation (GDPR) in May 2018.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- There were high levels of staff and patient satisfaction with the care and treatment provided. Staff were proud of working at the practice and spoke highly of their involvement in the running of the practice. Staff told us recent changes to uniforms and name badges had further increased the team spirit within the practice.
- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The practice also regularly monitored online comments and reviews and responded to these and they were shared in staff meetings. For example, feedback and comments on the practices social media accounts were regularly reviewed.
- The practice was engaged with the CCG, the local GP network and peers. We found the practice open to sharing and learning and engaged openly in multi-disciplinary team meetings.
- There was a virtual patient participation group with plans to progress to a coordinated group which would meet at regular intervals. Recent topics discussed with the group have included feedback about flu clinics, a review of the use of web based GP services and the development of the practice website.
- There was also an active 'friends of the practice' group. These groups of volunteers were supported by the practice to influence change and improve services for patients at the practice. We saw this group also

provided transportation services to all patients or carers - especially those who were lonely or isolated. We also saw the group was involved in raising funds for the practice.

- The service was transparent, collaborative and open with stakeholders about performance. Feedback from external stakeholders was positive about the practice performance and engagement.

Continuous improvement and innovation

The leadership team and all staff groups focused on continuous learning and improvement at all levels within the practice.

- The staff team were actively encouraged and supported with their personal development. This included the effective use of protected learning time and access to online and classroom training materials. This also included root analysis of significant events, learning and improvements through complaints and responding to data in relation to prescribing and best practice.
- As a GP training practice, the practice supported surgery swaps, openness of e-portfolio amongst trainers and peer to peer support for trainers. These steps were designed to support the continuous learning of the trainees. The practice were also working with two medical schools including a Fast Track Programme to support medical students.
- The practice had recognised existing and potential future challenges, including significant housing developments in the local area. The practice was active and worked collaboratively with the local GP Federation. (A Federation is the term given to a group of GP practices coming together in collaboration to share costs and resources or as a vehicle to bid for enhanced services contracts).

There was a clear proactive approach to seeking and embedding the provision of new strategies in the delivery of care and treatment. The practice team was forward thinking and proud to be initiators of many pilot schemes to improve outcomes for patients in the area. This included a number of innovative schemes that had been implemented or were in the process of development within the practice in order to improve the care for their patients. For example:

- The development of a service specifically for older people; this service was known as The Weston Service and had been recognised at a local and national level.
- The practice had recently launched the 'The Herbert Protocol'. An initiative introduced by national and local police forces, the Alzheimer's Society, health trusts and Dementia Action Alliances to provide police officers with early access to information when dealing with missing people living with dementia.

Please refer to the Evidence Tables for further information.