Newport Pagnell Medical Centre

Quality Report

Queens Avenue,
Newport Pagnell,
MK16 8QT
Tel: 01908 611767
Website: www.npmc.nhs.uk

Date of inspection visit: 27 September 2016
Date of publication: 05/12/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Newport Pagnell Medical Centre on 27 September 2016. Overall the practice is rated as **outstanding**.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, we saw evidence of an asthma protocol developed by the Respiratory Lead Nurse which was shared with the CCG and was then shared for use across the locality.
- Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility, choice and continuity of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result.
- The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together across all roles.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw several areas of outstanding practice including:

- The practice shared significant events with the Milton Keynes Clinical Commissioning Group (CCG) serious incident learning and review forum to share learning and improvements across the locality. The CCG used

Summary of findings

the data from the shared significant events to identify trends and areas of learning which were then shared across the locality to encourage improvements to standards of care.

- The practice ran a weekly drop in leg clinic, led by the practice nurse and district nursing teams. The clinic provided a holistic approach to care and aimed to support patients wholly rather than just focusing on their leg treatment needs. Mental health needs and the impact of a patient's condition on their general quality of life was also considered and supported accordingly. The practice had reviewed the effectiveness of this service through audit and had identified that wounds were fully healed within four months for 80% of patients seen at the clinic.
- The practice was classed as a POCT (point of care testing) hub practice within the locality, and alongside six other practices was offering patients additional services not normally found within a GP setting. For example, the Newport Pagnell Medical Centre was able to offer NT-BNP (for the early diagnosis of heart failure) and D-dimer testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).
- The Community Matron provided a weekly Carers Clinic providing carers with an opportunity to receive dedicated care and support. All carers were invited to attend for health and stress checks and where needed provided with care plans. In addition the Community Matron facilitated an open Carers Group at a local community hall, where carers of patients suffering with dementia could take their dependants and meet others in similar positions to themselves. This group was open to carers from across the locality.
- The practice facilitated an annual practice conference, bringing together all members of the practice. This was seen as an invaluable opportunity to ensure that all staff were included in the future planning of the organisation. Individual teams presented their work and achievements over the preceding 12 months, before presenting their strategic plans for the upcoming year. These individual team plans were then used to develop the overall strategic plan for the organisation, demonstrating a forward thinking culture of inclusion, equality and excellence.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Outstanding ☆

The practice is rated as outstanding for providing safe services.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation.
- Information about safety was highly valued and was used to promote learning and improvement both within the practice and across the locality through shared learning with the Milton Keynes Clinical Commissioning Group.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The practice maintained effective working relationships with other safeguarding partners such as in house health visitors and district nurses.
- There were systems in place to protect patients from the risks associated with medicines management and infection control.
- The practice demonstrated a thorough approach to staff training in management of emergencies; incorporating mock scenarios and role play as part of routine training. Records were kept and analysis was undertaken following an emergency event to ensure that risks to patients were reduced and learning was encouraged and shared.

Are services effective?

Good ●

The practice is rated as good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. For example, in keeping with NICE guidance the practice were offering alternative forms of anticoagulants to patients suffering from atrial fibrillation (AF) who were at risk of suffering strokes. (Anticoagulants are medicines used to prevent blood from clotting).

Summary of findings

- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were largely at or above the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Recognising the increased pressures on GP time and demands of a high proportion of elderly patients in their population the practice had employed an emergency paramedic. The paramedic was able to ensure a fast response to urgent calls, with GP support if required reducing the risk to patients of delayed intervention. The paramedic had undertaken additional training to enable him to support patients with long term conditions during acute attacks or upon presentation of worsening symptoms.
- The practice ran a service known as MK Diabetes Care which facilitated training for clinicians and patients across the locality. The team included Specialist Diabetes nurses and a Consultant session was held each week.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice ran a weekly drop in leg clinic, led by the practice nurse and district nursing teams. The clinic provided a holistic approach to care and aimed to support patients wholly rather than just focusing on their leg treatment needs. Mental health needs and the impact of a patient's condition on their general quality of life was also considered and supported accordingly. The practice had reviewed the effectiveness of this service through audit and has identified that wounds were fully healed within four months for 80% of the patients seen at the clinic. This was above national healing rates of 70% at 6 months. (Source: SIGN (2010) Management of chronic venous leg ulcers Clinical guideline No. 120. Scottish Intercollegiate Guidelines Network).
- The practice was proactive in encouraging patients to attend national screening programmes for cervical, breast and bowel cancer.

Are services caring?

The practice is rated as good for providing caring services.

Good

Summary of findings

- Data from the national GP patient survey published in July 2016 showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- All patients had a named GP and the practice ran a personal GP list system in an effort to provide continuity of care.
- The practice had identified 1.5 % of its patient population as carers. The Community Matron provided a weekly Carers Clinic providing carers with an opportunity to receive dedicated care and support. All carers were invited to attend for health checks and where needed provided with care plans. In addition the Community Matron facilitated an open Carers Group at a local community hall, where carers could take their dependants and meet others in similar positions to themselves.
- The practice had developed its own bereavement leaflet to offer guidance and support to patients. The Community Matron was also qualified to provide bereavement counselling to patients if required.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, the practice provided contracted physiotherapy services for the locality, sending physiotherapists to other local practices to provide services and providing care to patients within the practice itself.
- There were innovative approaches to providing integrated patient-centred care. For example, we saw evidence of an asthma protocol developed by the Respiratory Lead Nurse. The protocol was shared with the CCG and was then shared for use across the locality.
- In addition the practice worked in collaboration with the CCG to enable patients to receive care they would normally receive in secondary care at Newport Pagnell Medical Centre. At the time

Summary of findings

of our inspection the practice were able to offer clinics for Rheumatology, Vascular, Plastic Surgery, Gynaecology, Colorectal, Urology and Orthopaedics, enabling patients from across Milton Keynes to receive services in the community.

- The practice was classed as a POCT (point of care testing) hub practice within the locality, and alongside six other practices was offering patients additional services not normally found within a GP setting. For example, the Newport Pagnell Medical Centre was able to offer NT-BNP (for the early diagnosis of heart failure) and D-dimer testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).
- The practice had identified approximately 22% of its population to be aged over 65 years. They employed a Community Matron team to support their elderly patients in maintaining good health and maximising their quality of life.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- Patients said they were able to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

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

- The practice had a clear vision to deliver excellence and innovation in healthcare whilst maintaining the health of its community by using NHS resources effectively. High standards were promoted and owned by all practice staff and teams worked together across all roles.
- The management at the practice regularly reviewed and discussed services and future plans with staff to encourage a fully engaged and motivated practice team.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- The practice had a well-structured meetings system which covered all recommended areas.

Summary of findings

- The practice facilitated an annual practice conference, bringing together all members of the practice. This was seen as an invaluable opportunity to ensure that all staff were included in the future planning of the organisation. Individual teams presented their work and achievements over the preceding 12 months, before presenting their strategic plans for the upcoming year. These individual team plans were then used to develop the overall strategic plan for the organisation, demonstrating a forward thinking culture of inclusion, equality and excellence.
- There was a high level of constructive engagement with staff. We noted that the practice undertook regular staff satisfaction surveys, results of which were analysed and shared to ensure learning and improvement.
- The practice gathered feedback from patients and it had an engaged patient participation group (PPG) which influenced practice development. For example, the PPG had actively supported the opening of the branch surgery, conducted patient surveys and attended annual practice conferences to provide input, from a patient perspective, to the practice strategy.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- There was a strong focus on continuous learning and improvement at all levels.
- The practice demonstrated clinical innovation, for example through the vast array of additional services it provided. It had been at the forefront of developments to clinical services for the locality and was committed to diversifying services available in primary care.

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

Outstanding ☆

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice had identified approximately 22% of its population to be aged over 65 years. They employed a Community Matron team to support their elderly patients in maintaining good health and maximising their quality of life.
- The practice ran a weekly drop in leg clinic, led by the practice nurse and district nursing teams. The clinic provided a holistic approach to care and aimed to support patients wholly rather than just focusing on their leg treatment needs. Mental health needs and the impact of a patient's condition on their general quality of life was also considered and supported accordingly.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. The practice paramedic was able to support home visits, providing faster access to medical care when needed. The paramedic liaised with the GPs via their dedicated personal assistant to ensure that appropriate medication was available for patients if required.
- The practice provided regular ward rounds at a local residential and nursing homes for patients registered at the practice.
- The practice provided influenza, pneumonia and shingles vaccinations.
- A phlebotomy clinic ran daily enabling patients to have blood tests conducted locally rather than at the local hospital.
- The practice offered health checks for patients over the age of 75.
- All patients over the age of 75 had a named GP.

People with long term conditions

Outstanding ☆

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

- The practice maintained long term conditions (LTC) matrices for all chronic diseases. (A matrix can be defined as a set of conditions that provides a system in which something grows or develops). These matrix groups led on quality of care to ensure that it was evidence based, of high quality and reflected the most up to date best practice. The groups created their own annual strategic plans looking at improving quality year on

Summary of findings

year, based on audit and patient feedback. The groups were clinically led by a GP partner and include all District Nursing and Practice Nursing team leads, the quality manager (to report on audit findings) an administrative lead and a medical secretary. They worked to support patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).

- Performance for diabetes related indicators was comparable to the Milton Keynes Clinical Commissioning Group (CCG) and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last blood glucose reading showed good control in the preceding 12 months, was 76%, where the CCG average was 76% and the national average was 78%.
- The practice ran a service known as MK Diabetes Care which facilitated training for clinicians and patients across the locality. The team included Specialist Diabetes nurses and a Consultant session was held each week.
- The practice was classed as a POCT (point of care testing) hub practice within the locality, and alongside six other practices was offering patients additional services not normally found within a GP setting. For example, the Newport Pagnell Medical Centre was able to offer NT-BNP (for the early diagnosis of heart failure) and D-dimer testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with more complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding ☆

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Summary of findings

- The practice's uptake for the cervical screening programme was 87%, which was comparable to the CCG average and national averages of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice employed its own health visiting team ensuring a co-ordinated and integrated approach to caring for families with young children. We were told that amongst other initiatives the health visitors had ensured that the practice website was updated regularly to ensure young parents were able to review accurate information on the services available to them.
- Health Visitors offered support with minor ailments and referred patients to the Children's Primary Care Nursing Team as appropriate.
- Family planning and contraceptive advice was available.
- The practice worked in collaboration with the CCG to enable patients to receive care they would normally receive in secondary care at Newport Pagnell Medical Centre. At the time of our inspection the practice were able to offer clinics for dermatology, rheumatology and uro-gynaecology. We saw evidence that in the 12 months preceding our inspection a total of 1,525 patients, who would otherwise have been referred to secondary care for these services, had received care at the practice (239 for dermatology, 750 for rheumatology and 536 for uro-gynaecology).

Working age people (including those recently retired and students)

Outstanding

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice provided health checks to all new patients and carried out routine NHS health checks for patients aged 40-74 years.
- The practice offered a range of independent services (chargeable non NHS services) to patients including, physiotherapy, sports massage, Pilates, holistic therapy and yoga.
- Pre-bookable appointments were available from 8am till 12.30 pm on Saturdays.

Summary of findings

- The practice had enrolled in the Electronic Prescribing Service (EPS). This service enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

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

- The practice held a register of patients living in vulnerable circumstances including homeless patients and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access support groups and voluntary organisations.
- The practice held palliative care meetings involving district nurses, GP's and the local MacMillan Hospice nurses.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice had identified 1.5% of the practice list as carers. The practice made efforts to identify and support carers in their population. The Community Matron provided a weekly Carers Clinic providing carers with an opportunity to receive dedicated care and support. All carers were invited to attend for health checks and where needed provided with care plans. In addition the Community Matron facilitated a Carers Group at a local community hall, where carers could take their dependants and meet others in similar positions to themselves.
- The practice had developed its own bereavement leaflet to offer guidance and support to patients. The Community Matron was also qualified to provide bereavement counselling to patients if required.
- The practice was committed to ensuring that patients suffering from cancer were well supported. In an effort to improve services for these the practice had developed a leaflet regarding prostate cancer as this was an area that raised a lot of questions from patients. They had patient representatives who helped with designing and finalising the leaflet. They had

Summary of findings

developed a Cancer Care Matrix and integrated it into multi-disciplinary team meetings held to discuss palliative patients, ensuring that these patients were discussed and reviewed appropriately.
- The practice had developed a patient survey specifically for cancer patients to gauge how satisfied they were with the care they received and identify any areas in need of improvement. Patients undergoing chemotherapy received an alert card ensuring they received quick access to appointments as needed and were able to wait in a separate area to limit their exposure to other unwell patients; reducing their risk of infection.
- The practice was working with The British Red Cross to support the Syrian Resettlement Programme. As part of this programme the practice had registered four refugees and was supporting them in receiving required care.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

- Staff had a good understanding of how to support patients with mental health needs and dementia.
- Performance for mental health related indicators were comparable to local and national averages. For example, the percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 94% where the CCG average was 86% and the national average was 88%.
- The practice regularly worked with multi-disciplinary teams, including their Community Matron, in the case management of patients experiencing poor mental health, including those with dementia.
- An in-house counselling service was available for patients suffering from poor mental health, including postnatal mothers.
- The practice had told patients experiencing poor mental health about how to access support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line with local and national averages. 226 survey forms were distributed and 107 were returned. This represented a response rate of 47% (1% of the practice's patient list).

- 74% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 60% and national average of 73%.
- 94% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and national average of 76%.
- 88% of patients described the overall experience of this GP practice as good compared to the CCG average of 79% and national average of 85%.
- 85% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 71% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 17 comment cards which were all positive about the standard of care received. Patients commented on the excellent service they received, the fantastic approach of staff and clinicians and the well-maintained environment in which they were treated.

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

The practice also sought patient feedback by utilising the NHS Friends and Family test. The NHS Friends and Family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. Results from August 2016 showed that 93% of the 161 patients who had responded were either 'extremely likely' or 'likely' to recommend the practice.

Newport Pagnell Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a nurse specialist advisor and a practice manager specialist advisor.

Background to Newport Pagnell Medical Centre

Newport Pagnell Medical provides a range of primary medical services, including minor surgical procedures from its location on Queens Avenue, Newport Pagnell. The practice opened a branch surgery in August 2016, known as the NPMC at Willen practice, located on Beaufort Drive in Willen, Milton Keynes. We did not visit the branch surgery on the day of our inspection.

The practice serves a predominantly White British population of approximately 20,000 patients, with a largely average age range. There are slightly lower than average populations of males and females aged 10 to 29 years. The practice has also identified 22% of their practice population to be aged over 65 years. National data indicates the area is one of low deprivation in comparison to England as a whole.

The clinical team consists of four male and three female GP partners, two salaried GPs (both female), an emergency paramedic, a nurse team leader, seven practice nurses, three health care assistants (HCAs), two clinical supporters and two phlebotomists. The practice employs its own community nursing team consisting of a District Nurse, two senior community staff nurses, five staff nurses and three community HCAs. In addition, the practice employs a Community Matron team, (consisting of a Community Matron and HCA), a Health Visiting team (comprising four health visitors, a community nursery nurse and a designated secretary) and a Travel Clinic Team (comprising a dedicated travel clinic lead, an administration manager, a specialist travel nurse and three receptionists).

Alongside standard GP services the practice provides many additional advanced provider services, for example for diabetes, urology and physiotherapy, available to both their own patients and patients across Milton Keynes. The practice employs additional staff to provide these services. This includes four diabetes specialist nurses, nine diabetes educators (DESMOND trainers), six physiotherapists, an advanced urology nurse specialist, a staff nurse for urology and a specialist physiotherapist in pelvic floor dysfunction.

The team is supported by a managing partner, management team, administrative staff and a facilities team.

The practice holds a General Medical Services (GMS) contract for providing services, which is a nationally agreed contract between general practices and NHS England for delivering general medical services to local communities.

The practice is a training practice with an accredited GP trainer. At the time of our inspection there was one male GP registrar. (Registrars are qualified doctors training to become GPs). In addition the practice provided support for trainee nurses.

Detailed findings

The practice operates from a three storey purpose built property and patient consultations and treatments take place on the ground level and first floor. There is a car park to the rear of the surgery shared with the adjoining pharmacy, with adequate disabled parking available.

Newport Pagnell Medical Centre is open between 8am and 6.30pm Monday to Friday. In addition, pre-bookable appointments are available from 8am to 12.30pm on Saturdays. The branch surgery in Willen is open from 8am till 12pm and from 2pm till 6pm daily, Monday through to Friday.

The out of hours service is provided by Milton Keynes Urgent Care Services and can be accessed via the NHS 111 service. Information about this is available in the practice and on the practice website and telephone line.

Why we carried out this inspection

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

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 27 September 2016.

During our inspection we:

- Spoke with a range of staff including three GP partners, a member of the practice nurse team, the Respiratory Lead Nurse, Lead Nurse, a diabetes nurse, a District Nurse, the Community Matron, a health visitor, the paramedic, the manager partner and members of the management and administrative teams.
- We spoke with patients who used the service.
- Observed how staff interacted with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Outstanding ☆

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the Lead Nurse of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation, an apology as needed and were told about any actions to improve processes to prevent the same thing happening again. For example, a complaint was received from patient who was incorrectly booked to see a Health Care Assistant (HCA) for a procedure that the HCA was unable to conduct. We saw evidence that the practice conducted a thorough investigation, changed practice protocols where needed and provided additional training to staff to ensure they understood the scope of treatment that could be done within the practice. The patient received an explanation and apology.
- The practice shared significant events with the Milton Keynes Clinical Commissioning Group (CCG) serious incident learning and review forum. The lead nurse from the practice fed back significant events to this forum to share learning and areas of improvement or change. The CCG used the data from the shared significant events to identify trends and areas of learning which were then shared across the locality to encourage improvements to standards of care. For example, the practice shared a significant event involving a patient who presented with a grade 3 pressure ulcer. As a result several improvements and changes were made to the management of future cases within the locality, including improved integrated working with the local council and clearer guidance on primary care responsibilities for safeguarding. We noted the practice were the only practice within the locality providing this support to the forum.
- The practice conducted a thorough analysis of the significant events; where areas of learning were identified, the Lead Nurse audited the events and analysed the data for trends. We saw evidence of improvements made following analysis. For example, multiple significant events had arisen from poor care for patients requiring INR testing. (INR testing is used to monitor patients taking blood thinning medications). In response the practice formulated an INR matrix group to reduce the risk of errors and improve practice. (A matrix is a set of conditions that provides a system in which something grows or develops).

The practice demonstrated a strong focus on patient safety. We reviewed safety records, incident reports, MHRA (Medicines and Healthcare products Regulatory Agency) alerts, patient safety alerts and minutes of meetings where these were discussed. Safety alerts were received into the practice by the Lead Nurse who reviewed and actioned the alerts appropriately. A log of alerts received and action taken was also retained. The Patient Quality Manager was responsible for running searches and contacting patients potentially affected by alerts to ensure risk to patient safety was reduced. The practice maintained a safety alert notice board in the staff room, displaying all new safety alerts ensuring that all staff were made aware of them. Safety alerts were discussed routinely at clinical meetings.

We saw evidence that lessons learnt were shared and action was taken to improve safety in the practice. For example, following a safety alert received regarding possible drug interactions for patients with hypertension the practice conducted a drug interaction audit to ensure clinical safety for this group of patients. In 2011, following an audit, the practice identified 300 patients that were at risk of experiencing adverse reactions as a result of potential drug interactions. These patients were contacted and reviewed and the audit was repeated regularly to monitor patients at risk. In 2016, 15 newly registered patients with hypertension were identified to be taking medicines that may cause adverse reactions. All of these patients were contacted and their medication changed appropriately.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements.

Are services safe?

Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were GP leads for safeguarding; supported by a member of the health visiting team for child safeguarding and the Community matron for vulnerable adults. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children (level 3) and vulnerable adults relevant to their role. GPs were trained to the appropriate level to manage child (level 3) and adult safeguarding.

- The practice ensured that all patients with safeguarding concerns and their family members were offered appointments as a matter of priority. We were informed that the practice routinely reviewed children under the age of seven years not seen at the practice for three years; to ensure they were attending school and therefore receiving appropriate health checks. If these children were in alternative education, for example, home schooling, the practice offered them a health check.
- The practice employed its own health visiting team and we saw evidence that integrated working encouraged familiarity of vulnerable patients and enabled the practice to respond quickly to safeguarding concerns. All staff had immediate access to Health Visitors when needed ensuring that vulnerable patients were prioritised when required. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.
- We were told that employing the Health Visiting team had many benefits for the practice and its patients and directly enabled them to work closely as part of the primary care team. As a result they were able to liaise on behalf of the practice and undertake joint working with other community services such as Children's Centres, Pre Schools and Voluntary Services ensuring families got the most appropriate service. In addition due to the continuity of care they were able to offer families and children, including support with minor ailments, they were able to work closely with the doctors in identifying any safeguarding trends.
- Notices in the waiting room and clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The lead nurse was the infection control clinical lead who liaised with the local infection prevention team to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken with interim spot checks and we saw evidence that action was taken to address any improvements identified as a result. A comprehensive infection control report was published on the practice website informing patients of the practice's approach to infection control, including details of policies, staff training, dates of audits, findings, and details of the practice lead. In addition the practice provided advice and reassurance to patients with regard to the action that would be taken if there was a serious outbreak of a virus.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice managed medicines through a Prescribing Matrix Group which was led by two GP partners. (A matrix can be defined as a set of conditions that provides a system in which something grows or develops). This multi-disciplinary team met quarterly and managed all prescribing and medication issues within the practice and disseminated instructions from external organisations e.g. the community pharmacy team, National Institute for Health and Care Excellence (NICE) and MHRA.
- The practice carried out regular medicines audits, with the support of the Milton Keynes CCG pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Several of the nurses were qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group

Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The Lead Nurse undertook regular competencies checks to ensure nurses were using PGDs appropriately. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber, which logged in individual patient records.

- The nursing team were found to be working to the highest level and were receiving appropriate training and supervision to support this.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy available with a poster in the staff area which identified local health and safety representatives.
- The practice had up to date fire risk assessments and carried out regular fire drills. During fire drills the practice would rehearse scenarios using patient volunteers who would refuse to evacuate for example. This ensured that staff were well trained in case of an emergency. Fire alarms were tested weekly and the practice had a variety of other risk assessments in place to monitor safety of the premises such as Control of Substances Hazardous to Health (COSHH), infection control and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All electrical equipment was checked annually to ensure the equipment was safe to use and clinical equipment had been checked in February 2016 to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff informed us they worked flexibly as a team and provided additional cover if necessary during holidays and absences.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms and the practice used a tannoy system which could be accessed via all telephones to alert staff of an emergency.
- The practice recognised that it was located the furthest from the local hospital and ensured that all staff received extensive annual basic life support training. Training encompassed clinical training with mock emergency scenarios staged and administrative training where members of staff practiced a 'Crash Call' over the tannoy system, ensuring all staff were confident in their knowledge of what to do in an emergency. Following an emergency the practice undertook a debrief for the staff team to identify any areas of learning, improvement and good practice. Action plans were also completed to ensure that learning was followed through; demonstrating a commitment to patient safety and well-being. For example, we saw that following an emergency the practice had changed protocols to ensure that vital signs for patients in distress were recorded and logged at the practice prior to patients being transferred to hospital to ensure that an accurate patient record was maintained.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were maintained remotely.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. For example, in keeping with NICE guidance the practice were offering alternative forms of anticoagulants to patients suffering from atrial fibrillation (AF) who were at risk of suffering strokes. (Anticoagulants are medicines used to prevent blood from clotting).These alternative anticoagulants were beneficial to patients meeting the criteria for use as blood tests to monitor effectiveness were not required. At the time of our inspection 90 of the 270 patients requiring anticoagulants had been transferred to these alternative forms of medication.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available.

Data from 2014/2015 showed other QOF targets to be similar to local and national averages:

Performance for diabetes related indicators was comparable to the Milton Keynes Clinical Commissioning Group (CCG) and national averages. For example,

- the percentage of patients with diabetes, on the register, in whom the last blood glucose reading showed good control in the preceding 12 months, was 76%, where the CCG average was 76% and the national average was 78%. Exception reporting for this indicator was 14% compared to a CCG average of 13% and national average of 12%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Performance for mental health related indicators was comparable to local and national averages. For example,

- The percentage of patients with diagnosed psychoses who had a record of blood pressure was 100% where the CCG average was 92% and the national average was 90%. Exception reporting for this indicator was 19% compared to a CCG average of 15% and national average of 9%.
- The percentage of patients with hypertension in whom the last blood pressure reading (in the preceding 12 months) measured 150/90mmHg or less was 81% which was comparable to the CCG average of 81% and national average of 84%. Exception reporting for this indicator was 5% compared to a CCG average of 6% and national average of 4%.

There was evidence of quality improvement including clinical audit.

- There had been at least 14 clinical audits in the last two years, two of these were full cycle audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, an audit was undertaken to review patients prescribed medication to treat an overactive bladder. The first cycle of the audit identified 39 patients requiring a medication review in light of best practice guidance. The practice contacted all appropriate patients advising them of the changes to guidance and the rationale for changing their medication. A reaudit demonstrated an improvement to the practice's prescribing of medication for the condition.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

Effective staffing

- The practice had a comprehensive induction programme for all newly appointed staff devised by dedicated human resource staff. New staff received an

Good

Are services effective?

(for example, treatment is effective)

induction handbook to ensure they were well supported and training encompassed such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example we saw that nursing staff and health care assistants involved in reviewing patients with long term conditions such as diabetes and asthma attended regular updates and received training to support them specifically in these roles. Following training staff routinely shared learning with colleagues during clinical team meetings to ensure clinical care was provided in line with up to date best practice guidance at all times.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal in the last 12 months. The practice had recently reviewed its appraisal system and had developed a programme that encouraged two way communication ensured that staff were involved in their personal development and performance management. We saw that the practice encouraged its staff to develop and progress their skills and careers and maintained low staff turnover rates.
- We noted that the practice closed one afternoon each month to provide protected learning time for staff.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules, in-house training and training offered by other external providers.
- The practice was a training practice with a GP registered as a trainer. Registrars received regular debriefing after sessions, this acted to both supervise activities and support development.
- In an effort to provide patients with continuity of care the practice operated an individual list system ensuring patients were seen by the same clinician where possible. In response to difficulties recruiting new GP partners the practice employed long term locums to ensure patients were still able to receive a degree of consistency to their care.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs along with assessment and planning of ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. The practice held a register of patients at risk of unplanned hospital admission or readmission. We saw that patients on this register and any others who had been recently admitted or discharged from hospital were discussed at clinical meetings when needed. They benefitted from focused support which included priority access if required. At the time of our inspection there were 374 patients on the unplanned admissions register receiving this care.
- The practice held regular multi-disciplinary team (MDT) meetings to discuss all patients on the palliative care register and to update their records accordingly to formalise care agreements. The practice also encompassed all their Cancer patients in these meetings. They liaised with their in house District Nurses, Macmillan Hospice nurses and local support services. A list of the practice palliative care patients was also shared with the out of hours service to ensure patients' needs were recognised. At the time of our inspection 30 patients were receiving this care.

Good

Are services effective?

(for example, treatment is effective)

- The practice held regular safeguarding meetings in-house, attended by GPs, the practice nurse, health visitor and District nurses or Community Matron if needed. Other external stakeholders were also invited to these meetings as needed. Records were kept of discussions and actions taken in relation to children who may be at risk. Information from other agencies involved in safeguarding was also shared during these meetings.
- The practice had provided services to vulnerable patients under the locality Transformation In Care (TIC) pilot. This pilot aimed to support vulnerable patients to stay at home rather than be admitted to hospital by providing a rapid response service and liaising with other appropriate services to ensure patients received adequate care within their own homes. Recognising the increased pressures on GP time and demands of a high proportion of elderly patients in their population the practice had employed an emergency paramedic to support this programme. When the pilot ended the practice recognised the positive impact of the work done and continued to employ the paramedic in an effort to reduce hospital admissions and support vulnerable patients. The paramedic had undertaken additional training to enable him to support patients with long term conditions during acute attacks or upon presentation of worsening symptoms. The paramedic was able to ensure a fast response to urgent calls, with GP support if required, reducing the risk to patients of delayed intervention. The paramedic worked within his competence to manage patients needs as fully as possible by liaising with all necessary stakeholders and as required delivering prescriptions, agreeing review visits and leaving safe and appropriate worsening advice.
- The practice ran a service known as MK Diabetes Care which facilitated training for clinicians and patients across the locality. The team included Specialist Diabetes nurses and a Consultant session was held each week. Staff would visit other practices to offer training and support on diabetes care planning in an effort to standardise care across the locality. In addition nurses trained in diabetes education for patients (known as DESMOND trainers) provided support and advice to newly diagnosed diabetic patients. The practice worked in collaboration with the CCG to monitor standards of diabetic care across the locality.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. The practice utilised templates on their computer system to automatically alert them if a patient was aged 16 or under, guiding clinicians through a series of questions to ensure appropriate consent was taken.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or appropriate clinician assessed the patient's capacity and, recorded the outcome of the assessment.
- Written consent forms were used for specific procedures as appropriate.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- The practice maintained long term conditions (LTC) matrices for all chronic diseases, each with appointed GP leads. (A matrix can be defined as a set of conditions that provides a system in which something grows or develops). They worked with nurses trained in chronic disease management to support patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). (The practice was the first in the country to adopt the diabetes care planning model of care). Housebound patients received the same level of care from the district nursing and LTC teams within their own homes. Lead GPs for LTCs, specialist nurses, the managing partner, Lead Nurse, Quality Manager, an administrative lead and a medical secretary met every four months to review LTC provision to ensure it was of a high clinical standard and adhered to the most recent guidance. Any areas recognised as in need of improvement were encompassed in the practice's strategic planning to ensure action was taken appropriately.

Good

Are services effective?

(for example, treatment is effective)

- Patients who suffered from cardiovascular conditions or who had experienced a stroke were offered support from a dedicated team consisting of a GP lead, specialist nurse and dedicated administrator. These patients were also invited annually for reviews of medication, symptoms, lifestyle and general well-being before being provided with an action plan for management of their condition. Patients were referred to external agencies as needed, including the local Milton Keynes Cardiac group.
- The practice ran a weekly drop in leg clinic, for patients registered at the practice and those registered at a neighbouring practice. The clinic provided care of leg wounds, skin issues, ulcers and preventative care. Mobile and housebound patients, (supported by the Red Cross for transport) also had access to this clinic. This was a joint working group led by the Practice Nurse and District nursing teams. The clinic provided a holistic approach to care and aimed to support patients wholly rather than just focusing on their leg treatment needs. Mental health needs and the impact of a patient's condition on their general quality of life was also considered and supported accordingly. We were told that providing a club approach, treating people together and enabling them to meet others suffering similarly encouraged patients to not feel isolated by their conditions. The practice provided refreshments for patients and enabled them to interact socially during these clinics. This was particularly valued by these patients who were prone to isolation due to age, limited mobility and restricted access to transport. The practice has reviewed the effectiveness of this service through audit and had identified that wounds were fully healed within four months for 80% of the patients seen at the clinic. This was above national healing rates of 70% at 6 months. (Source: SIGN (2010) Management of chronic venous leg ulcers Clinical guideline No. 120. Scottish Intercollegiate Guidelines Network).
- The practice had reviewed the effectiveness of this service through audit and had identified that wounds were fully healed within four months for 80% of patients seen at the clinic. They noted this to be a significant improvement on figures for patients seen in isolation.

The practice's uptake for the cervical screening programme was 87%, which was comparable to the CCG and the national averages of 82%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice maintained a Cancer Awareness noticeboard in the patient waiting room and leaflets were available on varying forms of cancer and the importance of screening.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data published in March 2015 showed that:

- 63% of patients aged 60-69 years had been screened for bowel cancer in the preceding 30 months, where the CCG average was 56% and the national average was 58%.
- 83% of female patients aged 50 to 70 years had been screened for breast cancer in the preceding 3 years, where the CCG average was 76% and the national average was 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 64% to 100% and five year olds from 76% to 98%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74 years. At the time of our inspection, from the period January 2013 to September 2016, the practice had conducted 2,537 health checks of the 6,676 patients eligible (38%). Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

•

Kindness, dignity, respect and compassion

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

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

All of the 17 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

Results from the national GP patient survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and the national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 82%.
- 91% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- We saw that care plans were personalised and patients attending reviews for long term conditions were

provided with copies. In addition, patients unable to attend for reviews during normal opening hours were offered appointments on Saturdays or late evenings. Alternatively the practice offered telephone consultations for reviews.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 304 patients as carers (1.5% of the practice list). The practice had a carers champion who acted as an advocate for carers, ensuring they were able to access services easily and actively promoted the profile of carers within the practice. The Community Matron provided a weekly Carers Clinic offering carers an opportunity to receive dedicated care and support. All carers were invited to attend for annual health and stress checks and where needed provided with care plans. If carer's were unable to attend the practice, the Community Matron would visit the carer in their home and ensure they were seen in a separate room to their dependant enabling them to discuss concerns in privacy.

In addition the Community Matron facilitated an open Carers Group at a local community hall supporting those caring for others with dementia. Carers were able to attend the group from anywhere in Milton Keynes as it was an open group. Referrals to the group were also received from professionals at any point on the dementia pathway or from any other source. At the time of our inspection there were 39 members of whom 16 were registered at other GP practices. This group provided a forum for carers who could take their dependants and meet others in similar positions to themselves. Refreshments were provided and staff were on hand to offer advice and support to those that required it. Alternatively carers could use the opportunity to socialise whilst their dependants were being safely monitored. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice had developed their own bereavement leaflet to offer guidance and support to patients. The Community Matron was also qualified to provide bereavement counselling to patients if required.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Milton Keynes Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. We saw evidence of an asthma protocol developed by the Respiratory Lead Nurse. This was developed from looking at NRAD (National Register for Asthma deaths). The protocol was evidenced based and developed to ensure that patients were managed effectively and safely during an acute exacerbation of an asthmatic attack. The protocol was shared with the CCG and was then circulated for use across the locality.

We also saw evidence that the practice's Respiratory Lead Nurse created a video about the launch of a 'COPD self-management plan' with a member of the Respiratory Local Implementation Group. This group, led by a GP from another practice within the CCG, looked at how Milton Keynes could provide better care for all respiratory patients within the locality. NICE guidelines highlighted the use of self-management for respiratory patients, and evidenced a reduction in hospital admissions whilst using a care planning approach. They created a plan which was used across the whole locality, including the hospital and pulmonary rehabilitation service. The plan was developed with a team of specialists including primary and secondary care respiratory nurses, physiotherapists, pharmacists, GPs and microbiologist consultants. Expert patients were also consulted on the layout and usability of the plan. Once the group were happy with the self-management plan it was formally launched through a CCG platform. The launch was very successful with over 100 clinicians present. The video was created as an aid for training. The video shared best practice and helped to ensure that the plan was utilised fully.

In addition the practice worked in collaboration with the CCG to enable patients to receive care they would normally receive in secondary care at Newport Pagnell Medical Centre. At the time of our inspection the practice were able to offer clinics for community dermatology, rheumatology, uro- gynaecology, physiotherapy, vascular, plastic surgery, gynaecology, colorectal, urology and orthopaedics. The dermatology service was led by a GP with Specialist Interest (GPwSI) from within the existing practice team. The rheumatology clinic was led by an external Consultant Rheumatologist, supported in house by GPwSIs. The uro-gynaecology service was provided by an Advanced Urology Nurse Specialist, Specialist Physiotherapist in Pelvic floor dysfunction and a Staff Nurse.

Staff told us they had seen a positive response and that the locality had benefitted from the service as pressures on secondary care for these services had been relieved. For example, we were told that the rheumatology service had reduced demand on secondary services and managed 98% of patients within the community without needing onward referrals to secondary care. It provided early access for newly referred patients with inflammatory arthritis. At the time of our inspection, waiting times for the clinic were seven weeks compared to 13 weeks at the hospital based rheumatology clinics. Patients also received electronic reminders about their appointments reducing the incidences of missed appointments. GPs from across Milton Keynes were able to contact the clinic directly for urgent appointments and there were quick access routes for interventions such as steroid injections. This enabled patients experiencing acute flare ups to receive appropriate care in the rheumatology clinic within a week. Patients were also able to contact the clinic for help with queries, such as blood monitoring.

The practice was committed to the NHS England plan to bring treatment out of secondary care where possible and into the community. Staff informed us that the practice maintained low figures for the proportion of its patients referred to secondary care and this was largely due to efforts made by the practice to provide additional services to its patients. We saw evidence that in the 12 months preceding our inspection a total of 1,525 patients, who would otherwise have been referred to secondary care for these services, had received care at the practice (239 for dermatology, 750 for rheumatology and 536 for uro-gynaecology).

The practice was classed as a POCT (point of care testing) hub practice within the locality, and alongside six other practices was offering patients additional services not normally found within a GP setting. For example, the Newport Pagnell Medical Centre was able to offer NT-BNP (for the early diagnosis of heart failure) and D-dimer testing for patients. (D-dimer tests are used to rule out the presence of a blood clot). The practice was able to receive referrals from other practices across the locality to provide

these services to patients outside their own practice population. Since August 2015 the practice had offered this service to a total of 486 patients (303 BNP tests and 183 for D-dimer testing).

The practice had identified approximately 22% of its population to be aged over 65 years. They employed a Community Matron team to support their elderly patients in maintaining good health and maximising their quality of life. The Community Matron team provided holistic care and tailored support for these patients, including support for carers where needed. All new patients over the age of 75 years received a visit from the team. The team would support patients at home where needed, or at the practice either in person or over the telephone. In addition to providing health care support to these patients the Community Matron team would help them with routine tasks such as form filling and appointment booking. They liaised closely with local charities and support groups to further enhance the lifestyle of these patients. They also liaised closely with care home managers and wardens, acting as an early point of contact if patients became unwell. We were told of specific cases whereby the team had successfully supported patients at times of crisis for example, during bereavement.

The Community Matron team also managed those with complex long term conditions by offering a fast response time (within the same working day) which aimed to prevent hospital admission. We were told that carers and patients reported feeling a level of safety and confidence in the care offered by this team, increasing their quality of life.

- The practice provided longer visits for community patients with multiple medical and social needs, including those with learning disabilities with the aim of resolving as many as possible on the day when seen.
- The practice employed its own District Nursing Team which was integrated completely into the practice team, ensuring a cohesive approach to patient care, ensuring that care patients received in their homes was of an equal standard to that received in the practice.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice; these were conducted by GPs, District Nurses or the practice paramedic as appropriate.
- The practice provided regular ward rounds at a local residential and nursing homes for patients registered at the practice.
- The practice employed a domiciliary physiotherapist to visit housebound patients to support mobility and help maintain general function and independence.
- The practice recognised that many elderly patients with multiple health needs, required effective management to ensure their care was optimal and that housebound patients were able to receive required care at home rather than through admittance to secondary care. The District Nursing team, Community Matron team and Paramedic worked to ensure that the most appropriate team with the most appropriate skill mix attended to any given patient, hence ensuring that their immediate and ongoing needs were met effectively.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately, including Yellow Fever.
- There were disabled facilities, a hearing loop and translation services available. Staff had undertaken training in deaf awareness and we were told of plans to provide British Sign Language translation of the website.
- The practice was committed to ensuring that patients suffering from cancer were well supported. In an effort to improve services for these the practice had developed a leaflet regarding prostate cancer as this was an area that raised a lot of questions from patients. They had patient representatives who helped with designing and finalising the leaflet. They had developed a Cancer Care Matrix and integrated it into multi-disciplinary team meetings held to discuss palliative patients, ensuring that these patients were discussed and reviewed appropriately. The practice had also developed a patient survey specifically for these patients to gauge how satisfied they were with the care they received and identify any areas in need of improvement.
- The practice had created a 'chemo card' so that patients with cancer and receiving chemotherapy could be seen quickly within the practice for blood tests, appointments and other services once they showed their 'chemo card' in order to help protect their compromised immunity. Patients were reviewed after a cancer diagnosis within 6 months and invited to an

Are services responsive to people's needs?

(for example, to feedback?)

appointment with their usual GP to talk about their care as well as physical, social and emotional needs. A bespoke cancer review template had been created to help clinicians to go through all these areas with patients during their review.

- The practice ran an anticoagulant clinic three times a week for patients to monitor their treatment. (Anticoagulants are medicines used to prevent blood from clotting). At the time of our inspection the practice offered this service to 180 patients and was well received by patients as it reduced the need for them to travel to secondary care for the service.
- The practice employed its own health visiting team ensuring a co-ordinated and integrated approach to caring for families with young children. We were told that amongst other initiatives the health visitors had ensured that the practice website was updated regularly to ensure young parents were able to review accurate information on the services available to them. Health Visitors offered support with minor ailments and referred patients to the Children's Primary Care Nursing Team as appropriate.
- The practice provided an in house physiotherapy service for both patients registered at the practice and those who are referred from across the locality. We saw that between July 2015 and July 2016 the practice saw 3,103 new patients for physiotherapy assessments. In addition, during this time, 116 patients were seen in a domiciliary setting. The practice regularly reviewed this service and made improvements and changes in response to patient feedback and requirements. For example, following feedback, handouts were provided to patients during appointments to back up the advice given and help patients remember their exercises.
- A daily minor illness service was provided for patients requiring same day access, led by Minor Illness trained nurses, supported by a GP as appropriate.
- An in-house counselling service was available for patients suffering from poor mental health, including postnatal mothers.
- The practice provided space for consultant led clinics from the local hospital for Rheumatology, Vascular, Plastic Surgery, Gynaecology, Colorectal, Urology and Orthopaedics, enabling patients from across Milton Keynes to receive services in the community.
- The practice offered a range of independent services to patients including, physiotherapy, sports massage, Pilates, holistic therapy and yoga.
- The practice was working with The British Red Cross to support the Syrian Resettlement Programme. As part of this programme the practice had registered four refugees and was supporting them in receiving required care. It was envisaged that the practice would continue to take on more refugees as the programme developed.
- The practice had enrolled in the Electronic Prescribing Service (EPS). This service enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.
- The practice offered phlebotomy services Mondays to Fridays.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. In addition, pre-bookable appointments were available from 8am to 12.30pm on Saturdays. The branch surgery in Willen was open from 8am till 12pm and from 2pm till 6pm daily, Monday through to Friday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The practice provided a daily nurse led minor illness clinic providing on the day only appointments. Telephone consultations were available daily.

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

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 74% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% and the national average of 73%.

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

The practice had a system in place to assess:

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

Patients were able to telephone the practice to request a home visit and the practice paramedic would make an assessment and arrange the home visit appropriately,

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

either by a GP, District Nurse or the practice paramedic. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. The practice paramedic was able to support home visits, providing faster access to medical care when needed. The paramedic liaised with the GPs via their dedicated personal assistant to ensure that appropriate medication was available for patients if required. The paramedic would discuss a patient with the relevant GP and a prescription would be sent electronically to a local pharmacy of the patient's choice. Alternatively the paramedic would return to the practice collect the prescription and deliver it to patients directly. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- Where appropriate complaints were recorded as significant events and processed accordingly.
- We saw that information was available to help patients understand the complaints system on the practice website, in the practice leaflet and in the reception area.

We looked at 41 complaints received in the period April 2015 to March 2016 and found they had been dealt with in an open and timely way. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. Patients received an explanation of events and investigations and a written apology if required from the practice. We noted that the practice did not maintain a log of verbal complaints and staff informed us these were dealt with as they occurred. The practice informed us that they would maintain a log of verbal complaints in the future.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver excellence and innovation in healthcare whilst maintaining the health of its community by using NHS resources effectively. High standards were promoted and owned by all practice staff and teams worked together across all roles. The management at the practice regularly reviewed and discussed services and future plans with staff to encourage a fully engaged and motivated practice team.

The practice prided itself as a successful and innovative practice where all staff strove to provide excellent patient care. GP partners and managers were able to discuss the plans for the future and we saw evidence of regular partners meetings that were held, incorporating discussions around future planning. We saw evidence of forward thinking to maintain the smooth running of the practice and ensure patient care was not compromised. For example, the practice had successfully opened a new branch surgery in response to the needs of the locality.

The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored. We noted that strategy planning encompassed key learning and development areas identified following significant events, audits and changes to clinical guidance. It also embraced the Five Year Forward Plan for the NHS.

The practice facilitated an annual practice conference, bringing together all members of the practice. This was seen as an invaluable opportunity to ensure that all staff were included in the future planning of the organisation. Individual teams presented their work and achievements over the preceding 12 months, before presenting their strategic plans for the upcoming year. These individual team plans were then used to develop the overall strategic plan for the organisation, demonstrating a forward thinking culture of inclusion, equality and excellence.

Governance arrangements

Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice had a well-structured meetings system which covered all recommended areas.

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. We spoke with clinical and non-clinical members of staff who demonstrated a clear understanding of their roles and responsibilities.
- Practice specific policies were implemented and were available to all staff via the computer system, protocol file and staff handbook. We looked at a sample of policies and found them to be available and up to date.
- A comprehensive understanding of the performance of the practice was maintained using the Quality and Outcomes Framework (QOF) and other performance indicators. We saw that QOF data was regularly discussed and actions taken to maintain or improve outcomes for patients.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. We looked at examples of significant event and incident reporting and actions taken as a consequence. Staff were able to describe how changes had been made or were planned to be implemented in the practice as a result of reviewing significant events.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care, adopting a proactive and innovative approach to providing primary care services. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with

Are services well-led?

Outstanding ☆

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

patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment.

- The practice gave affected patients support, an explanation of events and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us that there was a high level of constructive engagement between the practice leadership and with staff.
- Staff told us the practice held regular team meetings. We saw evidence of minutes and agendas for these, which included GP partners meetings, management meetings, clinical meetings, matrix team meetings, multi-disciplinary team meetings and all staff meetings.
- Due to the large size of the practice team, innovative methods of communication had been adopted to ensure that all staff were kept informed; this included the provision of a monthly staff newsletter known as 'Surgical Spirit'.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team social events were held throughout the year.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. We spoke with a member of the PPG who told us that the practice was very responsive to any points raised. We saw evidence of collaborative working between the PPG and the practice. For example, the PPG had actively supported the opening of the branch surgery, conducted patient surveys and attended annual practice conferences to provide input, from a patient perspective, to the practice strategy.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. We noted that the practice undertook regular staff satisfaction surveys, results of which were analysed and shared to ensure learning and improvement. For example, following feedback from a staff survey the GPs provided input into the staff newsletter, taking it in turns to write sections of the newsletter.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice had provided services to vulnerable patients under a Transformation In Care (TIC) pilot. This pilot aimed to support vulnerable patients to stay at home rather than be admitted to hospital by providing a rapid response service and liaising with other appropriate services to ensure patients received adequate care within their own homes. This included ensuring that alternative care arrangements were organised for dependants if carers were unwell or admitted to hospital.

The practice demonstrated clinical innovation, for example through the vast array of additional services it provided. It had been at the forefront of developments to clinical services for the locality and was committed to diversifying services available in primary care. There was a focus on patient safety alongside improvement and the practice shared learning from significant events with the Milton Keynes Clinical Commissioning Group to ensure risks to patients were reduced across the locality.

We saw evidence of robust succession planning and forward thinking both in relation to the practice's own

Are services well-led?

Outstanding ☆

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

future and for primary care within the locality, with an emphasis on sustainability and development. For example, at the time of our inspection the practice were in liaison with other key stakeholders to implement the Integrated Diabetes Project in Milton Keynes to further improve the quality of care provided to patients within the locality, by providing additional support from a diabetes consultant when needed for example.

The practice had recognised existing challenges and potential future threats to its financial security and ability to continue providing services. In response the practice joined a federation known as Roundabout Health. (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). Through collaborative working with other practices in the federation the practice had been able to secure its future.