Walnut Tree Health Centre

Quality Report

Blackberry Court,
Walnut Tree,
Milton Keynes,
MK7 7PB
Tel: 01908 691123
Website: www.walnuttreehealthcentre.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Walnut Tree Health Centre on 24 August 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Whilst the majority of patients said they found it easy to make an appointment some commented on difficulty accessing appointments on occasion. The practice was actively recruiting for new GP partners and was aware of occasional difficulties accessing appointments. They were proactive in making changes to improve access.
- Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

- 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

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example, the practice was able to offer D-dimer and deep vein thrombosis (DVT) testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).

The areas where the provider should make improvements are:

- Develop systems to identify and support more carers in their patient population.
- Continue to monitor and ensure improvement to patient access to GP appointments.

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?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons learnt were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received support, an explanation of events, and a written apology. They were told about any actions taken to improve processes to prevent the same thing happening again.
- 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 health visitors.
- There were appropriate systems in place to protect patients from the risks associated with medicines management and infection control.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were largely at or above compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Clinical staff were aware of the process used at the practice to obtain patient consent and were knowledgeable on the requirements of the Mental Capacity Act (2005).
- The practice was proactive in encouraging patients to attend national screening programmes for cervical, breast and bowel cancer.
- The practice employs its own pharmacist to support effective medicines optimisation within the practice

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey published in January 2016 showed patients rated the practice in line with local and national averages 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.
- The practice had identified 0.2% of patients as carers and was developing systems to ensure all carers within their population were identified and supported.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Milton Keynes Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice offered a range of enhanced services including avoiding unplanned admissions to hospital and minor surgery.
- 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 practice was able to offer D-dimer and deep vein thrombosis (DVT) testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).
- The majority of 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. However, some patients commented on difficulty accessing appointments. The practice was proactive in developing improvements to improve access whilst they continued efforts to recruit new GP partners. For example, the practice had employed a pharmacist and increased nurse led minor illness appointments to alleviate pressures on GP appointments. They had also increased the number of GP telephone consultations available daily.
- The practice was committed to developing smarter ways of working and had developed two members of staff as patient

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care co-ordinators (PCCs). These PCCs were an intermediary between clinicians and patients offering additional information and support to patients, for example, with referrals, further alleviating pressures on GP time.
- 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.
- A Phlebotomy clinic ran daily enabling patients to have blood tests conducted locally rather than at the local hospital.

Are services well-led?

Good

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients in a safe and professional environment. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The practice was encouraging the patient participation group (PPG) to increase its involvement in the practice and was developing a virtual PPG to improve representation in the group.
- There was a strong focus on continuous learning and improvement at all levels.

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

Good

The practice is rated as good 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 was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice supported registered frail elderly patients in a local nursing home.
- 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, personalised care plans and priority access to GP care if needed.
- The practice recognised that some elderly patients were at risk of becoming isolated and had encouraged these patients to partake in an annual charity cake stall held during the flu vaccine clinics in an effort to encourage and develop social contact

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was comparable to the clinical commissioning group (CCG) and national averages. For example, the percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification within the preceding 12 months was 95%, where the CCG average was 91% and the national average was 88%.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with 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

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who may be 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.
- The practice's uptake for the cervical screening programme was 82%, 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.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- Family planning and contraceptive advice was available.

Working age people (including those recently retired and students)

Good

The practice is rated as good 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. For the period January 2013 to August 2016, the practice had completed 1,801 of 3,445 (52%) eligible health checks
- Pre-bookable appointments were available from 6.30pm till 9 pm on Mondays.
- The practice had increased the number of telephone consultations available daily.

Summary of findings

- The practice had enrolled in the Electronic Prescribing Service (EPS) in 2015. 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. We saw plans to introduce an advanced website which would increase online services, including the option to email queries to the practice.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people 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 in accordance with the national Gold Standards Framework (GSF) involving district nurses, GP's and the local Willen 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 24 patients (0.2% of the practice list) as carers. The practice was making efforts to identify and support carers in their population.

People experiencing poor mental health (including people with dementia)

Good

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

- The percentage of patients with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to 31/03/2015) was 73% where the CCG average was 78% and the national average was 84%.
- The practice provided dementia screening services for patients identified as at risk of developing dementia to allow for early intervention and support if needed.

Summary of findings

- The practice supported patients with dementia and we saw that several members of staff had undergone additional training to become dementia friends. These staff members wore badges to make them easily identifiable to patient requiring additional support.
- Performance for mental health related indicators were comparable to local and national averages. For example, 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 in the case management of patients experiencing poor mental health, including those with dementia.
- 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.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing comparably to local and national averages. 296 survey forms were distributed and 118 were returned. This represented 1% of the practice's patient list (a response rate of 40%).

- 51% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 59% and national average of 73%.
- 65% 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 75% and national average of 76%.
- 77% of patients described the overall experience of this GP practice as good compared to the CCG average of 76% and national average of 85%.
- 70% 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 69% and national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 83 comment cards which were all positive about the standard of care received. In particular, patients commented on the caring and empathetic attitude of staff and excellent standard of care patients felt they received.

We spoke with eight patients and a member of the patient participation group (PPG) during the inspection. (The PPG is a group of patients who work with the practice to discuss and develop the services provided). All informed us that they were highly 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 95% of patients who had responded were either 'extremely likely' or 'likely' to recommend the practice (42 responses were received).

Walnut Tree Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Walnut Tree Health Centre

The Walnut Tree Health Centre provides a range of primary medical services, including minor surgical procedures from its location at Blackberry Court, Walnut Tree, Milton Keynes.

The practice serves a population of approximately 10,600 patients with slightly higher than average populations of both males and females aged 30 to 54 years. The practice population is largely White British with small populations of Polish and Somalian patients. National data indicates the area served is one of less than average deprivation in comparison to England as a whole.

The clinical team consists of three female GP partners, two nurse practitioners (qualified as Independent Prescribers), two practice nurses, one health care assistant and a phlebotomist. The practice employs locums where possible to provide additional access, successfully securing two regular locums for two days.The team is supported by a practice manager, a deputy practice manager, two patient care co-ordinators, a reception manager and a team of administrative staff. In addition, the practice employs its own pharmacist to support effective medicines optimisation within the practice.

The practice recently changed its contract with NHS England and now 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 and a nurse practitioner also accredited as a GP trainer. A junior doctor had been in situ since September 2016. The practice was due to receive its new registrar in February 2017. (A registrar is a qualified doctor training to become a GP). In addition, it was providing support to a cohort of medical students from the new Buckingham University Medical School.

The practice had experienced some difficulties with staffing due to the departure of two out of five GP partners along with members of the administration team and the retirement of the practice manager. The practice was actively undergoing a recruitment process for new GPs to join the partnership and had successfully recruited a new practice manager and deputy.

The practice operates from a single storey purpose built property and patient consultations and treatments take place on ground level. There is a car park outside the surgery, with disabled parking available.

The Walnut Tree Health Centre is open between 8am and 6.30pm Monday to Friday. In addition, pre-bookable appointments are available from 6.30pm to 9pm on Mondays. The practice is a member of the local 'Prime Ministers Challenge fund' (PMCF) collaboration called MKExtra, enabling their patients, wishing to be seen outside of the practice's extended and core hours, to receive routine GP care at a network of practices across the locality.

Detailed findings

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 24 August 2016. During our inspection we:

- Spoke with a range of staff including two GP partners, three nurses, the practice manager and deputy and members of the administrative team.
- Spoke with patients who used the service and a representative of the patient participation group (PPG).
- 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.

Good

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 practice manager of any incidents and there was a recording form available in a central file and 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 reasonable support, an explanation, a written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, we saw that following a significant event the practice had taken action to ensure the necessary checks were carried out in future when prescribing medicines to delay menstruation.
- The practice maintained a log of significant events for analysis and they were discussed as a standing item on the agenda for practice meetings, to ensure that lessons learnt were shared and monitored.

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. We saw evidence that lessons learnt were shared and action was taken to improve safety in the practice. For example, we saw that when an alert was received regarding a batch of tests pots used for cervical smear samples a search was undertaken within the practice by an appropriate member of staff and all affected pots were removed from use as recommended in the alert. We also saw evidence that a public health report was received regarding changes to the Meningitis C vaccination. This was distributed to all staff and protocols were updated to ensure the most recent guidance was being followed. Copies of alerts were kept and available for staff in the practice.

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. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. We saw examples of referrals made for children highlighted as of concern. The practice also ensured that vulnerable children moving out of the practice catchment area remained registered with the practice until they were registered at another provider, ensuring they were monitored and supported appropriately at all times. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to the appropriate level to manage child (level 3) and adult safeguarding.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The practice 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. Six monthly infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, we saw that all floors in clinical areas had been changed following audit.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines

audits, with the support of the Milton Keynes CCG medicines management team and their own in house pharmacist, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- Blank prescription forms and pads were securely stored and there were newly developed systems in place to monitor their use Two of the nurses had 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 had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- 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 on the staff noticeboard which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. 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 July 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. The practice recognised that their clinical staffing levels were low following the departure of two GPs. We saw evidence that they were actively recruiting for GPs, utilising locums where possible and adopting smarter approaches to working to alleviate the pressures on staff. 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 which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in secure areas 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, key suppliers and stakeholder organisations. A copy of the plan was kept off site by the practice manager and partners and there was a cascade system in place to alert all staff in case of sudden closure.

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 through regular meetings and discussions. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. For example, we saw evidence that following an update to NICE guidance on treatment of COPD (Chronic Obstructive Pulmonary Disease) the practice had updated its protocols and shared learning with clinical staff.

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 99% 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 above the clinical commissioning group (CCG) and national averages. For example,

- the percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification within the preceding 12 months was 95%, where the CCG average was 91% and the national average was 88%. Exception reporting for this indicator was 9% compared to a CCG average of 8% and national average of 8%. (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 largely 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%. Exception reporting for this indicator was 0% compared to a CCG average of 18% and national average of 13%.

The percentage of patients with hypertension having regular blood pressure tests was 85% which was comparable to the CCG average of 81% and national average of 84%. Exception reporting for this indicator was 7% compared to a CCG average of 6% and national average of 4%.

There was evidence of quality improvement including clinical audit.

- There had been six clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored. For example, a recent audit had been undertaken to ensure that patients taking medicines that required regular monitoring were receiving the appropriate checks. The audit highlighted that the practice system was effective for monitoring and supporting these patients.
- Findings were used by the practice to improve services. For example, an audit was undertaken to ascertain asthma patients who were not managing their condition well; highlighted through inhaler overuse. Of the 633 patients registered as having asthma, 24 were identified as having requested more than 12 inhalers a year. These patients were invited for an asthma review to provide additional education and support. They were also tested to ensure there were no underlying causes of their excessive use, such as undiagnosed conditions. These patients continued to be monitored by the practice to ensure they received adequate support.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

Effective staffing

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

- The practice had a tailored induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Good

Are services effective?

(for example, treatment is effective)

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, we saw that nursing staff 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. We also saw that trainee nurses were well supported in developing their skills and knowledge to ensure they delivered good quality care to patients, through assignment to appropriate training courses and on role mentorship from colleagues.
- 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.
- We noted that the practice closed on ten afternoons each year 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 and in-house training.
- The practice was actively recruiting for new GPs to join the practice and recognised the pressures the clinical staff shortage placed on appointments and staff. They were employing locums where possible to provide additional access, successfully securing two regular locums for two days, in a bid to improve continuity of care. In addition the practice had made multiple changes to improve appointment availability. For example, the practice had employed a pharmacist to support medication reviews, alleviating pressures on GP time. A nurse practitioner had increased her sessions enabling her to provide additional minor illness clinics.
- Two members of the administrative team had been developed as patient care co-ordinators (PCCs). PCCs acted as an intermediary between the GPs and patients, providing additional support with referrals, tracking information and offering further information to patients when needed. Although only created in July 2016 it was envisaged that the role of the PCC would alleviate pressures on GP time. Early feedback from patients and staff had been positive with regard to the benefits of the PCC role.

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 computer 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 weekly clinical meetings when needed. At the time of our inspection there were 182 patients on the unplanned admissions register receiving this care.
- The practice held regular multi-disciplinary team (MDT) meetings that made use of the Gold Standards Framework (GSF for palliative care) to discuss all patients on the palliative care register and to update their records accordingly to formalise care agreements. They liaised with district nurses, Willen 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 seven patients were receiving this care.
- The practice held regular safeguarding meetings, attended by GPs, the practice nurse and health visitor.

Good

Are services effective?

(for example, treatment is effective)

Records were kept of discussions and action taken in relation to children at risk. Information from other agencies involved in safeguarding was also shared during these meetings.

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.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- 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.
- Health care assistants provided smoking cessation and weight management advice to patients with the option to refer patients to local support groups if preferred.
- Nurses trained in chronic disease management had lead roles in supporting patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).
- The practice provided contraceptive advice, including fitting of intra-uterine devices and implants.
- All patients over 75 had a named GP.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average and national averages of 82%. The practice demonstrated how they encouraged uptake of the screening programme by having a lead nurse for cervical screening, using information in different languages and information for those with a learning disability and by ensuring a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. We saw that in response to an increase in cancer diagnosis amongst its working age population the practice had created information boards, educating patients on the importance of screening and early detection. Data published in March 2015 showed that:

- 57% 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%.
- 77% of female patients aged 50 to 70 years had been screened for breast cancer in the preceding 3 years, where the CCG average was 74% 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 82% to 96% and five year olds from 91% to 96%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, patients over 75 years old and NHS health checks for patients aged 40–74 years. At the time of our inspection for the period January 2013 to August 2016 the practice had completed 1,801 of 3,445 (52%) eligible health checks for people aged 40 to 74 years.

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 83 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). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 87% 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%.
- 76% of patients said the GP gave them enough time compared to the CCG average of 80% 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 93% and the national average of 95%.
- 77% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 77% and national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 91%.
- 88% 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. However, results were slightly below local and national averages. For example:

- 77% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and the national average of 86%.
- 71% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and national average of 82%.
- 74% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 85%.

We saw that the practice reviewed the results of the GP patient survey and were proactive in addressing any areas identified as below average. For example, the practice aligned these lower scores to the changes in their clinical team and increased use of locums. As a result the practice had secured two long term locums and was making continued efforts to use the same locums where possible to provide continuity of care to their patients, whilst maintaining efforts to recruit new GP partners.

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

Good

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. These patients were also given longer appointments to account for the delay in communication when using an intermediary.
- Information leaflets were available in easy read format and different languages if required.
- A hearing loop was available for patients who suffered from impaired hearing.

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 24 patients as carers (0.2% of the practice list). The practice recognised this to be a low representation and at the time of our inspection was making efforts to identify carers in their population, for example, by developing a carer's notice board and providing additional information to carers encouraging them to identify themselves to the practice. Written information was available to direct carers to the various avenues of support available to them.

The practice recognised that some elderly patients were at risk of becoming isolated and had encouraged these patients to partake in an annual charity cake stall held during the flu vaccine clinics in an effort to encourage and develop social contact. We were told of plans to invite third sector organisations, such as Age UK to these events in the future to promote the services available to the elderly.

Staff told us that if families had suffered bereavement, their usual GP contacted them and 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.

Good

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. For example, the practice offered a range of enhanced services including avoiding unplanned admissions to hospital and minor surgery. The practice held multi-disciplinary meetings to discuss the needs of palliative care patients and patients with complex needs.

- The practice offered extended hours appointments on a Monday evening from 6.30pm till 9pm for patients who could not attend during normal opening hours.
- The practice maintained a register for patients with a learning disability; these patients were offered annual reviews and longer appointments when needed.
- A register of patients suffering from dementia was maintained and we saw that, between April 2014 and March 2015, 73% of these patients had received an annual review, (CCG average 78% and national average 84%). The practice provided dementia screening services for patients identified as at risk of developing dementia to allow for early intervention and support if needed.
- The practice supported patients with dementia and we saw that several members of staff had undergone additional training to become dementia friends.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- All patients over the age of 75 had a named GP, personalised care plans and priority access to GP care if needed.
- The practice offered phlebotomy services Mondays to Fridays.
- 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 practice was able to offer D-dimer and deep vein thrombosis (DVT) 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. We saw evidence that since 2010 the practice had undertaken 206 D-dimer tests and 90 BNP tests since 2013.
- The practice ran an anticoagulant clinic for patients to monitor their treatment. (Anticoagulants are medicines used to prevent blood from clotting). This clinic had been well received by patients as it reduced the need for them to travel to secondary care for the service.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- We saw that staff had received training on female genital mutilation and that there was information for patients displayed in the practice.
- 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.
- A HIV quick test was available for all new patients registering at the practice (that met specified criteria).

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Additionally, pre-bookable appointments were available from 6.30pm to 9pm on Mondays. 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 had also joined the local 'Prime Ministers Challenge fund' (PMCF) collaboration called MKExtra, enabling their patients, wishing to be seen outside of the practice's extended and core hours, to receive routine GP care at a network of practices across the locality.

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

Results from the national GP patient survey published in January 2016 showed that patient's satisfaction with how they could access care and treatment were slightly below local and national averages.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 71% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 78%.
- 51% of patients said they could get through easily to the practice by phone compared to the CCG average of 59% and national average of 73%.

The majority of people told us on the day of the inspection that they were able to get appointments when they needed them; however some commented on difficulty accessing appointments at times. The practice was aware of the pressures on appointments and difficulties incurred at times and attributed this to the clinical staff shortage. Whilst they maintained efforts to recruit new GP partners they were proactive in introducing further measures to improve access.

The practice was also keen to develop smarter ways of working to improve access. For example, the practice had increased the number of telephone consultations available whilst educating patients and staff on what could be facilitated through a telephone consultation rather than in a face to face consultation. We saw plans to introduce a new practice website which would improve the availability of online services to patients, including the option to email queries to GPs and nurses. Both of these initiatives were particularly beneficial to the high proportion of working age patients the practice served. In addition the practice had reviewed the roles of administrative staff against the needs of the practice and introduced a new patient care co-ordinator (PCC) role into the practice. These staff members acted as intermediaries between clinicians and patients providing additional support for example with referrals and patient requests, therefore alleviating pressures on GP time. Although the roles had only been developed a month before our inspection we were told that the PCCs had been well received by patients.

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 a GP would call them back to make an assessment and allocate the home visit appropriately. 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. 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.
- We saw that information was available to help patients understand the complaints system in the waiting room, at reception and on the practice website.

We looked at 16 complaints received in the last 12 months and found that the practice handled them objectively and in an open and timely manner. Lessons were learnt from individual concerns and complaints and actions were taken as a result to improve the quality of care. For example, we saw that when a patient complained about difficulty accessing appointments, the practice were prompt to investigate, before responding to the patient. The practice response offered information on the staff shortage the practice was experiencing as well as advice on the action the practice was taking to address the difficulties the patient had highlighted. The patient was also given advice on alternative methods of booking appointments, such as online, to ensure that the patient could access care when needed in the future. Staff were reminded of the appointments booking policy and the importance of educating patients on the availability of online appointment booking to reduce the risk of recurrence.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients in a safe and professional environment.

- The practice had a new management team who were focussed on engaging staff in developing the practice vision.
- The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored. We saw there was a focus on stabilising the practice workforce to ensure the security of the practice in light of proposed challenges, such as the population expansion in the locality and increased demand for practice services.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Organisational charts were displayed throughout the practice. 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 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

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

- The practice gave affected people reasonable 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 the practice held regular team meetings and we saw evidence of regular formal communications between the practice team.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

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. For example, the PPG had helped the practice develop patient surveys, providing input on suitable questions to ask. The new management team were in discussions with the PPG to increase their involvement in the practice and develop more opportunities for their input. We were told of plans to develop a virtual PPG to increase the representation of patients from the working age population which was prominent in the practice.
- 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.

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. 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 practice was able to offer D-dimer and deep vein thrombosis (DVT) testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).

We saw evidence of a commitment to learning and development within the practice, for example through the upskilling of existing staff. We saw that receptionists were training to become phlebotomists and that the practice had supported trainee nurses gain their qualifications. The practice provided support to a cohort of medical students from the Buckingham University Medical School. In addition we were told of plans for a new GP registrar to join the practice in September 2016 (a registrar is a qualified doctor training to be a GP).

The practice had recognised existing challenges and potential future threats to its financial security and ability to continue providing services. In 2014, 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.