Dr S A Mushtaq & Partners

Quality Report

Wolverton Health Centre
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr S A Mushtaq and Partners on 25 February 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe and well led services and good for providing effective, caring and responsive services. It was also good for providing services for each of the population groups we looked at.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to identifying significant events and disposal of out of date equipment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice had established good links with outside agencies including the local hospice and community services team
- Information about services and how to complain was available and easy to understand.
- 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 practice had a good relationship with the patient participation group.

The areas where the provider must make improvements are:

Summary of findings

- Document all actions taken when there has been a system or process failure and consider recording as a significant event so actions can be identified to prevent recurrence.
- Dispose of the out of date oxygen cylinder to prevent the risk of it being used in an emergency.

In addition the provider should:

- Implement a system for checking and recording the stock held in the GP bag used for home visits.
- Complete the business continuity plan and make it accessible to all staff.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. We noted an incident had not been recorded as a significant event and no actions had been identified to prevent the incident occurring again. We found an out of date oxygen cylinder that could potentially have been used in the event of an emergency.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. The practice's performance for cervical smear uptake was 86%, which was better than others in the CCG area.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Comment cards received indicated patients felt the practice offered an excellent service and staff were efficient, helpful and caring .Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Summary of findings

Patients had historically found it difficult to get through to the practice on the phone but changes had been implemented and some improvements had been made. Once through to the practice they said they found it easy to make an appointment with a named GP and that 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 that the practice responded quickly to issues raised. There was evidence that learning from complaints with staff and other stakeholders took place.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. 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 practice meetings incorporating governance. There were systems in place to monitor and improve quality and identify risk. However we identified two areas where risk had not been appropriately managed. There had been a failure in the maintenance of fridge temperatures that had not been recorded as a significant event with actions identified to prevent a recurrence. An out of date oxygen cylinder had not been disposed of which meant it could have been used in the event of an emergency. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

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. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice had a GP who led in the care of diabetic patients and worked with a practice nurse who had additional training in diabetes care. They worked with the patients to develop a care plan to help them manage their condition.

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 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. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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 was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice opened on a Saturday morning to cater for those patients unable to attend on a weekday. The practice employed a nurse to run a smoking cessation clinic on a Saturday morning which was popular for patients who were at work during the week.

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 those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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 an open registration policy where they would register vulnerable patients including homeless people.

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). People experiencing poor mental health were reviewed weekly by the GP and offered an annual physical health check. They were also offered longer appointment times as needed. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice was working with Age UK to identify those patients with early signs of dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

They were also working with Age UK to hold weekly clinics to help identify patients with potential symptoms of dementia.	

Summary of findings

What people who use the service say

Patients completed CQC comment cards to provide us with feedback on the practice. We received 35 completed cards. Twenty-four of these were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. A further nine comment cards were also positive about the doctors, nurses and reception staff but expressed difficulty in getting through on the telephone to book an appointment. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We spoke with two members of the patient participation group who were both complimentary about the practice and how it listened and acted on feedback.

The data from the National Patient Survey 2014 was reviewed. The survey was completed during a time of change for the practice when they were moving to new premises. This may account for lower than average scores in some areas however the practice scored well with 95% of respondents stating they had confidence and trust in the last GP they saw or spoke to and 93% said the last nurse they saw or spoke to was good at giving them enough time.

Areas for improvement

Action the service MUST take to improve

- Document all actions taken when there has been a system or process failure and consider recording as a significant event so actions can be identified to prevent recurrence.
- Dispose of the out of date oxygen cylinder to prevent the risk of it being used in an emergency.

Action the service SHOULD take to improve

- Implement a system for checking and recording the stock held in the GP bag used for home visits.
- Complete the business continuity plan and make it accessible to all staff.

Dr S A Mushtaq & Partners

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 further CQC inspector.

Background to Dr S A Mushtaq & Partners

Dr S A Mushtaq and Partners is also known as Wolverton Health Centre and provides a range of primary medical services to people in Wolverton, Milton Keynes. The practice population is of mixed ethnic background and is classed as a being a mid-deprivation area. The practice has a list size of just under 15,000 patients.

The contract held by Dr S A Mushtaq and Partners is a PMS contract. Personal Medical Services (PMS) agreements are locally agreed contracts between NHS England and a GP practice.

Clinical staff at the practice includes seven GP partners, six male and one female. There are five practice nurses and two health care assistants. The practice also has a number of reception and administration staff led by the practice manager.

The practice had moved into new purpose built premises one year ago. The GPs told us that the previous building was dilapidated and a lot of work had taken place by the GP partners, practice manager and the patient participation group to secure the new building.

The practice has opted out of providing out-of-hours services. This service is provided by Milton Keynes Urgent Care Service (MKUCS) and can be accessed by telephoning them direct, the number can be obtained from the practice answerphone or via the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. This 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.

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.

How we carried out this inspection

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?

Detailed findings

We also looked at how well services are provided for specific groups of people and what good care looks 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 February 2015. During our visit we spoke with a range of staff including GPs, nursing staff, the practice manager, reception and administration staff. We spoke with patients who used the service and members of the Patient Participation Group (PPG). We observed how people were dealt with by staff during their visit to the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. We saw that processes had been changed in response to incidents, for example, if a patient collapsed in reception an emergency button was pressed on the computer system, The electronic system in use at the practice alerted all staff in the practice. The patient was transported to the emergency treatment room and the duty doctor took a lead in managing the incident.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and were discussed as they arose. All events were reviewed every six months to identify trends and ensure actions had been implemented. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. We saw records of recent incidents and noted they were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example, improved communication from hospitals following the identification of abnormal test results to ensure that the correct treatment is initiated in a timely manner.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training which confirmed this.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and told us that the practice had a safeguarding lead and who this was. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The nurse we spoke with showed us the system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice held monthly meetings where safeguarding was discussed and the health visitor was in attendance. We saw minutes of these meetings and a schedule of meeting dates for the coming year. The practice manager also attended the Milton Keynes Safeguarding Forum which discussed relevant safeguarding issues with professionals from other organisations in order to share best practice.

A chaperone policy was in place and available for staff to read and there was a sign in the reception area informing patients of this. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) We saw certificates demonstrating that chaperone training had been undertaken by all staff that carried out chaperone duties including reception staff. The doctors we

spoke with informed us they routinely offered a chaperone and made a note in the patient's records if this was declined. They also said that they would take a chaperone on a home visit if required.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a system in place for ensuring medicines were kept at the required temperatures and these were checked by the practice staff. However, we noted that the fridge temperature for one week was recorded as above the accepted maximum temperature to maintain the viability of the medicines. When we spoke with the practice manager they explained that this had been investigated and the staff member had not recorded their actions to demonstrate the practice procedure had been followed to ensure the medicines remained fit for use. We noted that this incident had not been recorded as a significant event and no actions had been identified to prevent the incident occurring again. Since the inspection the practice manager has informed us that all staff have now been made aware that this type of incident needs to be documented as a significant event with actions taken and lessons learned documented.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to review of prescribing data and the practice worked with the clinical commissioning group (CCG) to address areas of prescribing where patterns were outside of the average for the rest of the CCG. For example, the practice had a high level of antibiotic prescribing. The practice was working with the CCG pharmacist to reduce this and audited their antibiotic prescribing each month. This showed a sustained decline in antibiotic prescribing.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and we saw that they were kept securely at all times.

The practice told us that the doctors did not have individual bags but used one bag which was taken out to home visits. We saw that this was stored securely and contained a comprehensive range of medicines which may be required. The practice told us that this was checked daily by the health care assistant. We checked and saw that all medicines were in date. However, there was no checklist for the health care assistant to refer to in order to determine what medicines were contained in the bag or a signing sheet to confirm this had been done.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw that the practice employed an external contractor to carry out the cleaning of the practice. We saw the cleaning schedule which covered all areas of the practice. The practice manager told us that they carried out a daily walkabout to ensure the cleaning standard was appropriate. We spoke with the practice nurse who also told us that the nursing staff carried out daily damp dusting in their own clinical areas in addition to the cleaning contractor's work. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control specific

to their role and there after annual updates which were carried out online. We saw certificates of training undertaken by staff. We saw evidence that the lead had carried out an infection control audit in October 2014 and that any improvements identified for action were completed on time. We saw from minutes of meetings that infection control was discussed

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury and we saw that staff had access to blood spill kits.

Hand hygiene technique notices were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw that the practice had accessed the services of an external company and records that confirmed the practice was carrying out regular checks in line with their recommendations in order to reduce the risk of infection to staff and patients. The practice manager had also undertaken training in assessing Legionella risk.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence to demonstrate that all portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure monitors and diagnostic machines.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. Criminal records checks via the Disclosure and Barring Service (DBS) had been carried out for all staff including receptionists who performed chaperoning duties. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure they was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us that only one nurse or reception staff member could be on leave at the same time.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative.

Whilst there was no collective risk log, we saw that risks had been identified and mitigated individually. Most risks had been assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

The practice told us that they had an open access policy for district nurses where they could contact the GPs at any time if they had concerns regarding patients. They also had good communication with the local pharmacies where they worked with them to improve outcomes for patients specifically those with mental health problems and vulnerable patients. They told us this was to ensure better management and understanding of their treatment.

Requires improvement

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We found that there was an oxygen cylinder which had expired in 2011 in the emergency treatment room. The practice informed us that the cylinder had been moved from their previous premises when they relocated one year ago but no arrangements been made to dispose of it. Whilst the cylinder was clearly marked 'out of date' and there were other oxygen cylinders available, there was a risk that it could have been used in an emergency. Since the inspection the practice manager has informed us that this oxygen cylinder has been removed.

All staff we asked knew the location of this equipment and records confirmed these were checked regularly. The practice gave examples of events where patients who had collapsed in the surgery. In response to this they had identified and allocated an emergency room equipped with emergency equipment for use in such situations. This was behind the reception area where patients could be dealt more appropriately and would prevent further distress to them and to other patients.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included a wide range of medicines including those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We saw that a full risk assessment had been undertaken and a protocol was in place to manage this. In the emergency room there were clear directions regarding resuscitation and dosages of medicines which should be given. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was no business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the practice. We spoke with the practice manager who told us that this was being developed. The practice manager was able to describe the actions they would take in the event of a major emergency which would take the practice out of action, but as this was not written down there was no direction available for other members of the practice staff.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. A GP we spoke with informed us of recent NICE guidance on the use of statins, a group of medicines to help lower cholesterol and how the practice was able to search their records for patients receiving this medication and review them as appropriate. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

All the GPs in the practice led on specialist clinical areas including dermatology, palliative care, diabetes and dementia. There was a list of the lead GPs clearly displayed in the reception area. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Two of the practice nurses had received training in chronic obstructive pulmonary disease (COPD) and asthma management. Whilst others took the lead on diabetes and immunisations. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. The GPs told us that this was a priority for the practice as they aimed to become a training practice in the next year. Our review of the clinical meeting minutes confirmed that this happened.

The practice manager showed us data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing; this showed they were prescribing higher than average antibiotics for their area. We saw evidence that they were working with the CCG pharmacist to reduce this by carrying out a monthly audit of antibiotics prescribed and showed a sustained decline in antibiotic prescribing. They had introduced a deferred antibiotic prescribing system which encouraged patients to only obtain their medication if their symptoms persisted. This had contributed to fewer antibiotic prescriptions being dispensed.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. There was an alert on the computer system for patients who had been recently discharged from hospital. The GP would review each patient's discharge notes individually and follow them up with a telephone call, home visit or a request to come into the practice according to need.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The GPs we spoke with informed us that referrals to secondary care are monitored and discussed at clinical meetings.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and administration staff to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken recently in addition to the monthly antibiotic prescribing audit. We saw that the audits undertaken demonstrated areas where treatment could be improved and that actions were taken to change patients treatment in response to this.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of ACE inhibitors, medicines used to treat high blood pressure and heart failure. Following the

Good

Are services effective?

(for example, treatment is effective)

audit, the GPs carried out medication reviews for patients who were prescribed these medicines and performed additional blood tests in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). The practice was an outlier for dementia diagnosis but had identified a GP to lead on dementia care and were working with the CCG to provide additional training in this area.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. The practice had a lead GP for training.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. The local hospice was included in the meetings to review patients on the register.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a good skill mix among the doctors with one having additional training in asthma care and another dermatology. All the GPs had special interests in which they took a lead in the practice, for example ENT, paediatrics and rheumatology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example two practice nurses had received training in asthma care. The practice was aiming to become accredited as a training practice in the next year and planned to have trainee GPs as well as medical students from Buckingham and Oxford universities.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical screening and wound dressings. Those with extended roles for example seeing patients with long-term conditions such as asthma, COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results and letters from the local hospital including discharge

summaries, out-of-hours GP services and the NHS 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for home visits for out of area patients was discussed and clarified at a recent practice meeting.

The practice held multidisciplinary team meetings each month to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The meetings had been planned in advance for the next year and similar meetings were held to discuss the needs of vulnerable children including those on the at risk register. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. We saw that the GPs used two computer screens which enhanced their ability to consult with the patients. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. To help staff the practice had a consent policy that gave guidance where capacity to make decisions was an issue for a patient. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. It also contained consent forms for different procedures carried out at the practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The consent policy gave guidance for documenting consent for specific interventions, for example minor surgical and gynaecological procedures. The policy contained consent forms used which were then kept in the patients notes with a record of the relevant risks, benefits and complications of the procedure. The policy also covered consent for access to medical records and guidance on parental responsibility for consenting to treatment for children under the age of 16 years.

Health promotion and prevention

It was practice policy to offer a health check with a health care assistant to all new patients registering with the practice. The GP was informed of all health concerns

Good

Are services effective?

(for example, treatment is effective)

detected and these were followed up in a timely way. The GPs informed us they use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. These were done by the health care assistants and any patients identified with high risk factors for disease were referred to a GP and scheduled for further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, patients experiencing poor mental health were reviewed each week by a GP and offered longer appointment times as needed. The practice kept a register of all patients with a learning disability and offered them an annual physical health check this included checking the patient's weight and blood pressure. Three reminder letters were sent to these patients offering the health check to ensure optimum uptake.

The practice had also identified the smoking status of 91% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. The practice employed a nurse to run a smoking cessation clinic on a Saturday morning which was popular for patients who were at work during the week. The health care assistants were also trained in smoking cessation and were available to offer appointments during the week as required.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 86%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients did not attend.

The practice held immunisation clinics weekly and offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

A midwife also attended the practice weekly to run baby clinics. Additionally the GPs conducted routine 8 week medical examinations for babies and maternal post-natal checks.

The practice had a GP who led in the care of diabetic patients and worked with a practice nurse who had additional training in diabetes care. The GP was also the diabetic lead for 27 practices in Milton Keynes. The practice nurse promoted a self-management model of care for the patients with diabetes. The patient would attend an appointment with a health care assistant for blood tests, weight and blood pressure monitoring as well as foot checks. The results of the tests are sent to the patient at their home and when they have an appointment with the practice nurse they are asked about their condition and test results. The nurse then worked with the patient to develop a care plan to help them manage their condition.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 100 patients undertaken by the practice's patient participation group (PPG). The national patient survey 2014 was done at a time of change for the practice when they were working in their old premises and moving to the new building.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect but the practice rated below the CCG average with 68% of respondents to the national patient survey 2014 who described the overall experience of their GP surgery as fairly good or very good. However the practice was average compared to others in the locality with 77% who stated the last GP they saw or spoke to was good at listening to them and 75% said the last GP they saw or spoke to was good at giving them enough time.

The national patient survey results indicated the practice was rated above the CCG average with 95% of respondents stating they had confidence and trust in the last GP they saw or spoke to and 91% stating the last nurse they saw or spoke to was good at treating them with care and concern.

The practice was also average for its satisfaction scores on consultations with doctors and nurses. Seventy-six percent of practice respondents stated that the last time they saw or spoke to a GP; the GP was good or very good at treating them with care and concern.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 35 completed cards. Twenty-four of these were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. A further nine comment cards were also positive about the doctors, nurses and reception staff but expressed difficulty in getting through on the telephone to book an appointment. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed how staff dealt with patients during our inspection and noted that they treated patients respectfully. The practice switchboard was located away from the reception desk. There was one telephone operator at the reception desk who was shielded by a glass partition which helped keep patient information private. Several patients we spoke with told us that they did have to wait to see the doctor when they had arrived at the surgery. Patients commented that it would benefit them if the practice put information on the patient information board indicating whether doctors or nurses were running late and also give an indication when they were expecting a call from the doctor approximately when it would be.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, 77% of practice respondents felt the GP was good at explaining treatment and results and 78% stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care which was average compared to the local CCG.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Several patients we spoke with told us of specific times when the doctors had provided prompt and appropriate action and referral to more specialist services when they needed it. They told us that the doctors had discussed the issues with them and explained the need for referral. They also told us that the doctors were good at continuing to monitor their conditions.

Some patients we spoke with told us that the doctor visited them at home when they were not able to get to the surgery and another patient told us that they were able to get an urgent appointment when their child was sick without any difficulty.

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. Some of the practice staff were multilingual and fluent in languages such as Polish, Punjabi and Hindi. The practice also used internet translation sites to assist with consultations when necessary.

The practice nurse told us that they use an empowerment model of care which allowed the patients to take control and be involved in their treatment and management. Patients with a long term condition that we spoke with confirmed that they felt their long term condition was managed well and that they felt well informed regarding their treatment and how to deal with their condition.

Patient/carer support to cope emotionally with care and treatment

We saw that notices in the patient waiting room signposted people to a number of support groups and organisations for example AGE UK and the Alzheimers Association. The practice's computer system alerted GPs if a patient was also a carer. We saw written information available for carers to ensure they understood the various avenues of support available to them.

We also saw that the patient participation group had organised a Carers Awareness Week for March 2015. Minutes from a recent PPG meeting with the practice showed that Carers MK, an independent charity established to support unpaid, family carers in the Milton Keynes area had been invited to attend and it was discussed that local schools would be informed so young carers were aware of the event.

Staff told us families who had suffered bereavement were contacted by their usual GP and would be offered a consultation if appropriate at a flexible time and location to meet the family's needs and/or signposting to a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had an open access system in place whereby patients on the end of life register, those with learning disabilities and the over 75s with complex needs could access the practice on a direct dial telephone number. This enabled them to speak to a GP or book a same day appointment.

The NHS England Area Team and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The practice manager was a member of the local practice forum and attended regular meetings.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A common theme to feedback from patients via the PPG was that they had difficulty getting through to the practice on the telephone. We saw an action plan was put in place in response to this and the practice had changed the telephony system increasing the number of lines into the practice and recruited additional reception staff. Online appointment booking via the practice website went live in November 2014.

The PPG also reported that patients had been queueing outside the practice in the morning to get an appointment. In response to this the practice introduced telephone consultations and posted information in the patient newsletter and local Wolverton and Greenleys town council newsletter educating patients about when they needed to see a GP.

We spoke with two members of the PPG on the day of the inspection. Both commented on how well the practice worked with them to meet the patients' needs and that the practice manager and GPs were supportive and engaged with the group. They stated that the practice was trying hard to make improvements and listened to feedback.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had an open registration policy where they would register vulnerable patients including homeless people. They were also working with Age UK to hold weekly clinics to help identify patients with potential symptoms of dementia.

The practice had access to online and telephone translation services and many of the GPs were multi lingual.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The premises and services had been adapted to meet the needs of patient with disabilities. We saw that there were ramps to access the building. All the corridors and doors were wide enabling wheelchair users to navigate the building independently. In the reception area we saw a low level reception desk. There was room under the desk for wheelchairs which enabled the patient to get closer to the receptionist to avoid their conversation being overheard. All the consulting rooms were on the ground floor. There were two disabled parking bays next to the building with further allocated disabled parking in the car park. There was a hearing loop in the reception area for those patients with hearing difficulties.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice actively supported patients who have been on long-term sick leave to return to work by reviewing them regularly often by telephone consultation. They would avoid signing them off sick for more than 28 days, without a review.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were available from 8 am to 6.30 pm on weekdays. Pre-bookable appointments were also available from 8 am to 11.30 am on Saturdays. The practice employed a nurse to run a smoking cessation service on a Saturday morning and if needed would pre-book practice nurse appointments on a Saturday. Patients could book a face to face GP appointment or a telephone consultation.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. Appointments could be booked online through the website up to six weeks in advance. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service, Milton Keynes Urgent Care Service (MKUCS) was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Patients were generally satisfied with the appointments system although access to the practice via the telephone was a common theme of negative feedback from the patients we spoke with and on the comment cards received. The practice was aware of this and had taken steps to increase their reception staff and recruit a reception manager.

Patients confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

The practice's extended opening hours on Saturday mornings was particularly useful to patients with work commitments. This was confirmed by feedback received on the comments cards. Two patients also commented that the online appointment booking was easy to use.

Listening and learning from concerns and complaints

The practice had a 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 on the practice website and in the practice leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at all complaints received in the last 12 months and found they had been satisfactorily handled in a timely way. We saw that apologies to patients had been made when appropriate and a GP had taken responsibility to access additional learning as part of their continuous professional development on a specific condition. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. As a result of one complaint a poster had been placed in the waiting room advising that emergencies could not be dealt with on a Saturday morning and how patients should access emergency care.

Are services well-led?

Requires improvement

(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. We found details of the vision and practice values were part of the practice charter that was contained within the practice leaflet. This included that the practice would strive to improve its services and the levels of health care on a continuous basis and that staff were friendly and approachable and would greet patients courteously and with respect.

We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We observed staff and their interactions with patients which showed they were aware of the values contained in the practice charter.

We saw that the practice aimed to be accredited as a training practice this year with one of the GPs taking a lead on education and learning. Comments made by staff members indicated they felt this was a positive step and that there had been increased levels of learning within the practice in preparation for this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We saw that there were also hard copies available in the reception area. We looked at a number of these policies and procedures and found that they had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The clinical staff took part in a local peer review system with neighbouring GP practices. The practice manager was a member of the local practice forum and showed us that best practice was shared within the group.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. They reviewed their antibiotic prescribing each month and had recently completed an audit of patients receiving ACE inhibitors, medicines to treat high blood pressure and heart failure and their blood test results.

The practice had arrangements for identifying, recording and managing risks. There was not a formal risk log in the practice but minutes from the practice meetings showed that risks were discussed and any actions were communicated to staff. However we identified two areas where risk had not been appropriately managed. There had been a failure in the maintenance of fridge temperatures that had not been recorded as a significant event with actions identified to prevent a recurrence. An out of date oxygen cylinder had not been disposed of which meant it could have been used in the event of an emergency. Since the inspection the practice manager has informed us that all staff have been informed of the process to follow when a significant event occurs and the oxygen cylinder has been removed from the practice.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example management of sickness, disciplinary and grievance procedures which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the

Are services well-led?

Requires improvement

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

results of the annual patient survey and saw that a high percentage of patients were not happy with the service and information received by the reception staff. We saw as a result of this the practice had arranged for supervision of the reception staff by the office manager and practice manager and had advertised to recruit two reception supervisors. The practice had also arranged for the reception staff to receive training in customer care and conflict resolution.

The practice had an active patient participation group (PPG) a group of patients registered with the surgery who have no medical training but have an interest in the services provided. The group predominantly included representatives from the practices older population but were actively trying to recruit younger members. The group carried out yearly surveys and met monthly with the practice manager and any GPs that were available to attend. The practice manager showed us an action plan that had been agreed as a result of the survey information. The results and actions agreed from these surveys were available on the practice website. Meeting agendas and minutes were also available on the practice website.

The practice had gathered feedback from staff through staff meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice manager told us that members of the reception team were taking a lead in different areas, for example, one of the receptionists had shown an interest in dementia care so had received additional training and was working with the lead GP for dementia care to improve awareness within the practice. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice aimed to become a GP training practice within the next year. One of the GPs was the lead for training and education. The practice was planning to take GP trainees (experienced hospital doctors who are gaining experience to enter General Practice) and medical students from Buckingham and Oxford universities

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example the practice had introduced a system of key fobs allocated to staff to allow them access as appropriate to the keys for the medicines cupboards. This tracked which staff member had used the keys and when.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We identified two areas where the provider had not managed risk appropriately. This was in relation to not recording a significant event when there had been a failure in the maintenance of the fridge temperature and an out of date oxygen cylinder had not been disposed of which meant it could have been used in the event of an emergency. This was in breach of regulation 10(b) of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2010, which corresponds to regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.