

# Oakridge Park Medical Centre

## Quality Report

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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

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## Overall summary

### Letter from the Chief Inspector of General Practice

**We carried out an announced comprehensive inspection at Oakridge Park Medical Centre on 17 January 2017. 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.

- The majority of patients said they found it easy to make an appointment, with urgent appointments 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 two areas 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 example, the practice was able to offer D-dimer testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).
- The practice invested considerably in the provision of an Echocardiography service, for both patients registered at the practice and those registered at other practices within the locality. (An echocardiogram (echo) is a test that uses high frequency sound waves

# Summary of findings

(ultrasound) to make pictures of your heart).The service was established 25 years prior to our inspection, by the lead GP. Appointments were available throughout the week and during a dedicated Saturday Clinic. We saw that between June 2016 and October 2016 the practice saw 264 patients under the cardiology service.

The areas where the provider should make improvements are:

- Monitor systems to record actions taken in response to safety alerts, to ensure they are effectively implemented.

- Continue to monitor and improve provisions for patients with mental health concerns.
- Develop systems to identify and support more carers in their patient population.
- Continue to monitor and ensure improvement to patient access to GP appointments.
- Encourage all staff to complete mandatory training in a timely manner and in accordance with the practice schedule for completion.
- Continue with efforts to stabilise the clinical team through active recruitment.

**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?

The practice is rated as good for providing safe services.

Good



- 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. The practice had recently employed a Pharmacist to support medicines optimisation within the practice.
- Health and safety risk assessments, for example, a fire risk assessment had been performed and were up to date.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were largely comparable to Clinical Commissioning Group (CCG) and national averages, although indicators relating to mental health were slightly below average.
- Staff assessed needs and delivered care in line with current evidence based guidance. We saw evidence of regular discussions on updated guidance in clinical meetings. For example, we saw that following a review of NICE guidance the practice had discussed changes to the use and management of anticoagulant medicines to ensure the best possible outcomes for patients. (Anticoagulants are medicines used to prevent blood from clotting).

# Summary of findings

- Clinical audits demonstrated quality improvement and we were told of plans to expand audits undertaken as the clinical team stabilised. The newly appointed pharmacist was also to be included in audit work in the future.
- 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. We noted that the practice encouraged staff to upskill and train for additional qualifications. For example a practice nurse had recently become an accredited Independent Prescriber.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs, including the community District Nursing Team based on site.
- 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.

## Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey published in July 2016 showed patients rated the practice below local and national averages for several aspects of care. The practice had attributed this to staff turnover and difficulties patients had experienced in accessing appointments with their preferred GPs. We saw evidence of successful recruitment of long term locum clinicians and continued efforts to stabilise the clinical team. The nursing team had also been expanded to improve access.
- 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 less than 1% of patients as carers and was continuing with efforts to ensure all carers within their population were identified and supported. We saw that a member of staff had trained as a Carers Champion. The practice

**Good**



# Summary of findings

had developed a carer's notice board and was working towards completing the local Council scheme, 'Investors in Carers GP Standard Award' in recognition of its commitment to supporting patients who are unpaid carers.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff 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 such as avoiding unplanned admissions to hospital and diabetic reviews. In 2014 the practice was involved in the locality transformation in care scheme to reduce unplanned admissions.
- The majority of patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day, others commented on difficulty accessing appointments. The practice was proactive in developing improvements to increase access. They had successfully recruited new clinical and non clinical staff and extended appointment availability through expansion of the nursing service. A long term locum Independent Nurse Prescriber provided a minor illness/injury service. They had also secured long term locum GPs to improve continuity of care.
- 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.
- 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 testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).
- The practice invested considerably in the provision of an Echocardiography service, for patients registered at the practice and those registered at other practices within the locality. (An echocardiogram (echo) is a test that uses high frequency sound waves (ultrasound) to make pictures of your heart). The service

# Summary of findings

was established 25 years ago by the lead GP. Appointments were available throughout the week and during a dedicated Saturday Clinic. We saw that between June 2016 and October 2016 the practice saw 264 patients under the cardiology service.

## Are services well-led?

Good



- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The practice had an ethos which placed patients at the centre of their service provision. They were focused on continuous improvement with the statement 'okay is not good enough, we should do even better'.
- 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 patient participation group (PPG) was active.
- The leadership, governance and supportive culture of the practice was used to drive and improve the delivery of good quality person-centred care.
- The partners, along with the practice manager encouraged a culture of integrity, care and compassion both within their team and towards patients.
- There was a focus by the practice on continuous improvement of the quality of care and treatment provided, which meant improved patient outcomes.
- We saw that the practice demonstrated resilience and was proactive in overcoming challenges, for example through successful recruitment and adjustments to their appointment system to improve accessibility.

# Summary of findings

## The six population groups and what we found

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

### Older people

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

Good



- The practice were passionate about providing care for elderly patients, employing a dedicated community health care assistant and an AgeUK worker to support elderly patients at risk within their own homes. These patients all had direct access to the practice via a designated telephone number and all had tailored care plans in place.
- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- All patients over the age of 75 had a named GP.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- 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 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.
- The practice offered health checks for patients over the age of 75.

### People with long term conditions

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

Good



- Specialist nurses for long term conditions led chronic disease management clinics supported by GPs 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, in whom the last blood glucose reading showed good control in the preceding 12 months (1 April 2015 to 31 March 2016), was 76%, where the CCG average was 77% and the national average was 78%.



# Summary of findings

- Longer appointments and home visits were available when needed.
- The practice provided an insulin initiation service for diabetic patients.
- A recall system was utilised to manage these patients.
- Patients with long term conditions benefitted from continuity of care with their GP or nurse. 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.
- All discharge summaries were reviewed on the day they were received ensuring medicines were adjusted and appropriate primary care follow-up was arranged.

## Families, children and young people

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.
- 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 of 82% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Children and infants who were unwell were always seen on the same day.
- The practice organised their own appointments and follow ups for childhood immunisations. As a result the practice had no waiting lists for children needing immunisations and there was provision of appointments outside of school hours or at a flexible time to increase access.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- Family planning and contraceptive advice was available. The practice provided a variety of health promotion information leaflets and resources for this population group for example the discreet provision of chlamydia testing kits.

Good



# Summary of findings

## 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 telephone consultations daily.
- The practice had enrolled in the Electronic Prescribing Service (EPS). This service enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.
- The practice encouraged the use of the on line services to make it easier to book appointments and order repeat prescriptions.
- The practice encouraged screening for working age people such as bowel screening and cervical screening. Practice staff followed up any patients who did not respond to screening invitations so that they knew they were welcome to make contact if they wished to re-engage.
- The practice was 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.

## 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 had developed a register of patients in vulnerable circumstances including patients with no fixed address and those from traveller communities.
- 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, including corroborative working at locality wide multi-disciplinary meetings.
- 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 MacMillan Hospice nurses.

# Summary of findings

- 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 less than 1% of the practice list as carers. The practice was continuing with efforts to ensure all carers within their population were identified and supported. We saw that a member of staff had trained as a Carers Champion.

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

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 (1 April 2015 to 31 March 2016) was 72% where the CCG average was 86% and the national average was 84%. The practice recognised mental health as an area in need of improvement and we saw that efforts were being made to recall patients, with all patients receiving three reminders. Patients with mental health concerns also received a phone call from the practice inviting them in for review. We saw evidence that these efforts were being effectively implemented and were improving performance over time.
- 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 regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice held a register of patients experiencing poor mental health and invited them to attend annual reviews. 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.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing below local and national averages in most indicators. 288 survey forms were distributed and 116 were returned. This represented less than 1% of the practice's patient list (a response rate of 40%).

- 69% 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%.
- 54% 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 70% and national average of 76%.
- 67% of patients described the overall experience of this GP practice as good compared to the CCG average of 79% and national average of 85%.
- 61% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 71% and national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 comment cards in total, of which 25 were positive about the standard of care received. In particular,

patients commented on the clean environment, polite and caring staff and the high level of care they felt they received from the doctors and nurses. Some comments recognised the difficulties the practice had experienced with recruitment of doctors and commended the team for their continued efforts to provide excellent care. We also received positive feedback from a patient via our online share your experience webform. This feedback commended the dedication of the practice team and high level of care they provided. Four negative comments surrounded difficulty accessing appointments.

We spoke with five 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). Whilst they all informed us that they were pleased with the standard of care they received, one patient stated that they had found it difficult to arrange an appointment. Patients we spoke to described the staff as pleasant, accommodating and compassionate. Some patients also commented that they were aware of the difficulties the practice had experienced in recruiting doctors and that staff remained professional and accommodating despite these added pressures.

# Oakridge Park Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

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

## Background to Oakridge Park Medical Centre

Oakridge Park Medical Centre provides a range of primary medical services, including minor surgical procedures from its location at Texel Drive, Oakridge Park in Milton Keynes.

The practice serves a population of approximately 12,300 patients with slightly higher than average populations of males and females aged 0 to 9 years and 25 to 39 years. The practice population is largely White British, with increasing populations of European and Asian patients. National data indicates the area served is one of slightly less than average deprivation in comparison to England as a whole.

The clinical team consists of two male GP partners, a female salaried GP (currently on maternity leave) a lead nurse, three practice nurses (one of which had recently qualified as a prescriber), three health care assistants (HCAs) and two phlebotomists. The practice had recently employed a pharmacist to support clinicians with medicines optimisation. The team is supported by a practice manager, an assistant practice manager, a reception manager and a team of administrative staff. In addition the practice employed four long term locums (three female and one male), a locum Independent Nurse Practitioner (qualified as a prescriber), a community HCA and an Age UK worker.

In the 18 months preceding our inspection the practice had experienced an unusually high turnover of both clinical and non clinical staff. The practice told us that this had impacted on access to appointments and patient satisfaction. We saw that the practice had successfully recruited additional nursing and administrative staff and at the time of our inspection were making continued efforts to recruit more doctors on a long term basis. The practice was being supported by the Milton Keynes Clinical Commissioning Group (CCG) and NHS in the recruitment and retention of GPs.

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

The practice operates from a two storey purpose built property which opened in 2012. Patient consultations and treatments take place on the ground level and first floor. There is a large car park outside the surgery, with disabled parking available. The building is owned by NHS property services and the practice shares these premises with Trust community staff (District nurses).

Oakridge Park Medical Centre is open between 8am and 6.30pm Monday to Friday. 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.

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.

# Detailed findings

## 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 17 January 2017. During our inspection we:

- Spoke with a range of staff including two GP partners, a practice nurse, the practice manager 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.

# 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 on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation, a written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, we saw that when an error in prescribing was identified, the practice were prompt to explore the incident and respond to the patient, conducting necessary investigations to ensure the patient was not at risk. A search was undertaken to ensure no other patients had been affected by the error and practice protocols were adjusted to ensure that the risk or recurrence was reduced.
- The practice maintained a log of significant events and they were discussed as they occurred. We were told that as the practice team was becoming more stable the practice planned to restart previous processes for reviewing and analysing significant events. For example by discussing them 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. 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 device used by patients with diabetes, a search of patients was undertaken and affected patients were contacted to advise them of the alert. Copies of alerts were kept electronically and in a folder by the practice manager;

however details of actions taken were not recorded. Following discussions during our inspection, the practice informed us that they intended to keep records of action taken in response to alerts for staff to access and refer to.

### 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 member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. 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 on the waiting room TV screen and in clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The lead nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and the majority of staff had received up to date training. We saw that staff outstanding their infection control update training were scheduled to complete the training by the end of February 2017. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements



## Are services safe?

identified as a result. For example, we saw that following an audit the practice had replaced all fabric chairs in consulting rooms with chairs with non-porous covers.

- 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 Clinical Commissioning Group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. In addition the practice had employed a pharmacist to support medicines optimisation within the practice. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had recently qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. We were told of plans for this nurse to receive 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 in the office area 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 three yearly with interim checks undertaken by a caretaker to ensure the equipment was safe to use. Clinical equipment was checked annually to ensure it was working properly, with the most recent checks having been undertaken in March 2016.
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. Staff informed us they worked flexibly as a team to try and provide additional cover if necessary during holidays and absences and the practice employed locum staff if needed. The practice provided an induction for locums and maintained appropriate records including background checks, proof of identification and registrations.

### 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 a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were kept off site by the practice manager, assistant manager and lead GP.



# 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, including regular discussions at clinical meetings. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. For example, we saw that following a review of NICE guidance the practice had discussed changes to the use and management of anticoagulant medicines to ensure the best possible outcomes for patients. (Anticoagulants are medicines used to prevent blood from clotting).

### 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 94% of the total number of points available. The practice had a lead GP for QOF and held regular meetings to discuss QOF performance.

Data from 2015/2016 showed QOF targets to be similar to local and national averages:

Performance for diabetes related indicators was in line with the Clinical Commissioning Group (CCG) and national averages. For example,

- the percentage of patients with diabetes, on the register, in whom the last blood glucose reading showed good control in the preceding 12 months, was 76%, where the CCG average was 77% and the national average was 78%. Exception reporting for this indicator was 11% compared to a CCG average of 14% and national average of 13%. (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 generally below local and national averages. For example,

- The percentage of patients with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (1 April 2015 to 31 March 2016) was 72% where the CCG average was 86% and the national average was 84%. Exception reporting for this indicator was 10% compared to a CCG average of 7% and national average of 7%. The practice recognised mental health as an area in need of improvement and we saw that efforts were being made to recall patients, with all patients receiving three reminders before being exception reported. Patients with mental health concerns also received a phone call from the practice inviting them in for review. We saw evidence that these efforts were being effectively implemented and were improving performance over time. For example these figures demonstrated a marked improvement on the preceding years performance (1 April 2014 to 31 March 2015) where the practice achieved 37% for this indicator.
- The non-responders to mental health reviews also had their records reviewed by the mental health lead and assessed by phone or by home visits at least once a year.

The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months (01/04/2015 to 31/03/16) was 150/90mmHg or less was 77% which was comparable to the CCG average of 82% and national average of 83%. Exception reporting for this indicator was 5% compared to a CCG average of 6% and national average of 4%.

There was evidence of quality improvement including clinical audit.

- There had been four clinical audits completed in the last two years, three of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, in October 2015 the practice conducted an audit of patients prescribed oral nutritional supplements (ONS) to determine the appropriateness of ONS. They identified 21 patients who needed a review of their care and the ONS they were prescribed. The audit was repeated in May 2016 and they had reduced the

# Are services effective?

## (for example, treatment is effective)

number of patients prescribed ONS to 13, having identified more appropriate treatment plans for the other patients. The practice also identified four new patients prescribed ONS.

- The practice participated in local audits, national benchmarking, accreditation, peer review and research. We were told that due to clinical staff shortages the practice had been unable to undertake as many audits as they had done historically and that they hoped to increase auditing as their clinical team stabilised. They also planned to involve their recently appointed Pharmacist in undertaking additional audits.

### Effective staffing

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

- The practice had an induction programme for all newly appointed staff, including locums. All new staff received a tailored induction pack which covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We spoke to recently appointed staff who informed us that they felt well supported in their roles and that they had received a comprehensive and valuable induction.
- 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.
- 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 practice was a hub practice for nurse training, supporting trainee nurses from the University of Northampton. The salaried GP was undertaking a training programme to become an accredited GP trainer.
- 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 saw that clinical supervision records were tailored to individual need and encouraged development. All staff had received an appraisal within the last 12 months.

- 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. We noted that some members of staff were overdue their update training, however a risk assessment had been undertaken for these staff and a schedule was in place for all outstanding training to be completed by the end of February 2017.

### 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.
- We saw that the community District Nursing team were based on the practice site and we were informed that this helped to facilitate effective communication and joint working to support vulnerable patients through instant access to each other.
- Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs along with assessment and planning of ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. The practice held a register of patients at risk of unplanned hospital admission or readmission. We saw that patients on this register and any others who had been recently admitted or discharged from hospital were discussed at clinical meetings when needed. Patients who were identified as

# Are services effective?

## (for example, treatment is effective)

at risk of unplanned hospital admission had access to a direct line to the practice and were guaranteed an appointment or a call back from a clinician as appropriate. These patients also had care plans in place. At the time of our inspection there were 231 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, Macmillan Hospice nurses and local support services. A list of the practice palliative care patients was also shared with the out of hours service to ensure patients' needs were recognised. At the time of our inspection 11 patients were receiving this care.
- All discharge summaries were reviewed on the day they were received ensuring medicines were adjusted and appropriate primary care follow-up was arranged.

### 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

- 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 were signposted to the relevant service.
- The lead nurse provided smoking cessation 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). We saw evidence that patients who did not attend (DNA) their appointments received reminder letters and/or a telephone call to further encourage attendance.

- The practice provided contraceptive advice, including fitting of intra-uterine devices and implants.
- The practice provided a variety of health promotion information leaflets and resources for young people. For example the provision of chlamydia testing.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 82% and the national average of 81%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available.

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

- 52% 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%.
- 76% of female patients aged 50 to 70 years had been screened for breast cancer in the preceding 3 years, where the CCG average was 76% and the national average was 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 77% to 98% and five year olds from 93% to 97% (CCG average 91% to 96%, national average 88% to 94%). The practice had reviewed its childhood immunisations service in light of changes to the vaccination programme and extended appointments to ensure that adequate time was provided to staff reducing the risk of errors. An administrator supported nurses during appointments to further reduce pressures on clinical staff. We saw evidence of action taken to ensure children received appropriate vaccinations, for example the practice organised their own appointments and follow ups for childhood immunisations. As a result the practice had no waiting lists for children needing

## Are services effective?

(for example, treatment is effective)

immunisations and there was provision of appointments outside of school hours or at a flexible time to increase access. In addition, patients who DNA were followed up by the practice.

Patients had access to appropriate health assessments and checks. These included new patient health checks and NHS health checks for patients aged 40–74 years. During the period December 2010 to December 2016, the practice had

conducted 1,330 health checks of the 3,154 patients eligible (42%). Health checks were also offered for patients over the age of 75 years. For the period April 2014 to December 2016, the practice had conducted 284 health checks of the 567 patients eligible (50%). Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# 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.

Of the 27 patient Care Quality Commission comment cards we received 25 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. Some comments recognised the difficulties the practice had experienced with recruitment of doctors and commended the team for their continued efforts to provide excellent care. We also received positive feedback from a patient via our online share your experience webform. This feedback commended the dedication of the practice team and high level of care they provided. Four negative comments described difficulties accessing appointments and dissatisfaction during a consultation with a doctor.

We spoke with five patients and a member of the patient participation group (PPG). Whilst they all informed us that they were pleased with the standard of care they received, one patient stated that they had found it difficult to arrange an appointment. Patients we spoke with described the staff as pleasant, accommodating and compassionate. Some patients also commented that they were aware of the difficulties the practice had experienced in recruiting doctors and that staff remained professional and accommodating despite these added pressures. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 76% 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%.
- 71% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.
- 82% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 88% and the national average of 92%.
- 73% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 78% and national average of 85%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 91%.
- 74% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

The practice attributed these lower than average satisfaction scores to the high usage of locum staff in the year preceding our inspection. They were also aware that patients preferred to see one of the two GP partners wherever possible, as they had built an excellent rapport with patients over time. However, due to the pressures created by the clinical staff shortage, the practice was unable to fulfil these requests. We saw that the practice continued to make efforts to improve patient satisfaction and to recruit a more stable clinical team, having successfully secured four long term locums. Reception staff had also been provided with additional training as needed, in an effort to improve satisfaction. The practice also undertook its own patient surveys with the support of the PPG and we saw evidence that the results of their surveys were positive and demonstrated high levels of patient satisfaction.

The practice employed a long term locum Independent Nurse Practitioner who provided three minor illness clinics each week, for three full days, in an effort to alleviate pressures on GP appointments. A practice nurse had



## Are services caring?

recently qualified as an Independent Prescriber and we were told of plans to increase the availability of nurse led minor illness clinics to further improve access and consistency.

### Care planning and involvement in decisions about care and treatment

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

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

- 73% 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%.
- 67% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 82%.
- 85% 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%.

The practice again attributed lower scores in some areas to the high usage of locums and the unsettlement that had caused with some patients who had historically seen one of the GP partners. The practice informed us that as their clinical team stabilised they hoped to see an improvement in the results of the national patient survey.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- 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.

- The practice provided braille signs on all clinical rooms to enable partially sighted or blind patients a degree of independence.

### 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. New patient registration forms were comprehensive and enabled the practice to quickly identify patients that may need additional support, for example those with a learning disability, those with carers, patients in need of an interpreter and those with a registered disability.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 91 patients as carers (less than 1% of the practice list). The practice was making continued efforts to identify carers in their population, for example, by developing carer's notice board and working towards completing the local Council scheme, 'Investors in Carers GP Standard Award' which recognised GP practices that supported patients who are unpaid carers. We saw that a dedicated member of staff trained as a Carers Champion and the practice was proactive in encouraging carers to identify themselves to the practice. The Carer's Champion was also trained as a Dementia Friend enabling the practice to further support patients with Dementia. The practice worked with the PPG to facilitate carers coffee mornings at the practice, providing an opportunity for carers to socialise with others and to receive advice and support in an informal setting. Written information was also available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and would wherever possible visit to offer support. 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. This care was extended to families of the deceased who were not registered with the practice themselves; if staff were concerned about their wellbeing or how they were coping.

# 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. The practice offered a range of enhanced services such as avoiding unplanned admissions to hospital and diabetic reviews. In 2014 the practice was involved in the locality Transformation in Care scheme to reduce unplanned admissions. The practice had targeted their efforts on elderly patients over the age of 75 years, employing a dedicated community health care assistant and an Age UK worker to support elderly patients at risk. Through this effort we saw evidence that the practice had significantly reduced unplanned hospital admissions and received recognition for implementing one of the most successful initiatives within the locality.

The practice were passionate about providing care for elderly patients and we saw that despite funding being removed in 2016 for the transformation scheme, the practice continued to employ the community health care assistant and the Age UK worker to support elderly patients at home. These patients all had direct access to the practice via a designated telephone number and all had tailored care plans in place.

We saw that the practice had invested considerably in the provision of an Echocardiography service, for both patients registered at the practice and those registered at other practices within the locality. (An echocardiogram (echo) is a test that uses high frequency sound waves (ultrasound) to make pictures of your heart). The service was established 25 years ago by the lead GP. We saw that the practice had invested in equipment including 12 lead electrocardiograms and two echo machines. (An electrocardiogram is a test that checks for problems with the electrical activity of your heart). The lead GP provided this service throughout the week and during a dedicated Saturday Clinic, when he was supported by a technician. The Saturday Clinics provided an all-encompassing service; with patients received a clinical opinion on the same day as having an echo conducted. We saw that between June 2016 and October 2016 the practice saw 264 patients under the cardiology service. In addition the practice provided numerous cardiology services, including ambulatory blood

pressure monitoring and ambulatory heart rhythm monitoring. Ambulatory Blood Pressure Monitoring (ABPM) is when a patient's blood pressure is being measured as they move around, living their normal daily life. Ambulatory heart rhythm monitoring measures a patient's heart rhythm as they move around, following their normal daily routine.

- 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 testing and BNP testing for patients. (D-dimer tests are used to rule out the presence of a blood clot. The BNP test (Brain natriuretic peptide) is used to diagnose heart failure in patients with unexplained shortness of breath). 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 342 D-dimer tests and 425 BNP tests since 2013.
- There were longer appointments available for patients with a learning disability.
- 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.
- 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.
- The practice was able to initiate insulin treatment for patients with diabetes. We were told that the practice was the first within the locality to provide this service and had been doing so since 2002. The provision of this service in house reduced the pressures on secondary care services.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately, including Yellow Fever.
- The practice offered helicobacter breath testing; a test for diagnosing the presence of a bacterium in the stomach, enabling quicker diagnosis and initiation of treatment when required.

# Are services responsive to people's needs?

## (for example, to feedback?)

- There were disabled facilities, a hearing loop and translation services available. Braille signs were in use on consultation room doors. There was a lift to improve access to the first floor for both patients and staff with limited mobility.
- The practice provided space for a community physiotherapy service three times per week in an effort to support efforts to improve access to physiotherapy services for patients.
- 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.

### Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were available for people that needed them.

The practice had reduced booking times to two weeks in advance in an effort to reduce the high numbers of failed appointments and improve access to appointments for those requiring them. The practice informed us that the number of 'did not attend' appointments (DNAs) had reduced since making this change. For example, DNA rates dropped from 400 in July 2016 to 176 in December 2016.

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 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 July 2016 showed that patient's satisfaction with how they could access care and treatment was slightly below local and national averages.

- 64% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 76%.

- 69% 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%.

We saw that the practice had made efforts to improve patient satisfaction with opening hours by joining the local 'Prime Ministers Challenge fund' (PMCF) collaboration called MKExtra, enabling their patients, wishing to be seen outside of the practice's core hours, to receive routine GP care at a network of practices across the locality. Given the shortage of clinical staff, we were informed it was not viable for the practice to offer any further extended hours appointments at the time of our inspection.

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 or nurse 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. The practice made concerted efforts to provide care for patients in their own home where needed and in particular for the vulnerable elderly patients.

### 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 12 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



## Are services responsive to people's needs? (for example, to feedback?)

their dissatisfaction with a delay in receiving their blood test results, the practice were prompt to investigate, before responding to the patient. The practice reassured the patient that any abnormal results would have been prioritised and explained. We were told of improvements made to the practice following complaints, such as the

provision of high back chairs in the waiting areas for patients with disabilities or health concerns that would benefit from a more supportive chair. The nursing service had also been expanding in response to complaints received around access.

# 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.

- The practice had an ethos which placed patients at the centre of their service provision. They were focused on continuous improvement with the statement 'okay is not good enough, we should do even better' included in their strategy.
- The practice was aware of challenges, especially with regard to recruitment and retention of GPs. The practice had seen the departure of several GPs in the 18 months preceding our inspection and this had impacted on patient satisfaction and performance. However we saw that the GP partners and practice manager took pride in their cohesive team and had a strong vision, expertise and willingness to invest time and funds to ensure that the service continued to evolve and meet the needs of its patients.
- The practice had a business development plan and a statement of purpose which reflected the vision and values and were regularly monitored.

### 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. Lead roles and responsibilities were clearly assigned and documented for all staff to refer to. 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 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. The practice informed us of plans to expand audit work undertaken to include the recently appointed Pharmacist.
- 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 and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. We saw that the practice had undergone significant challenges in the 18 months preceding our inspection. Not only through the loss of clinical staff and difficulties recruiting but also through the sudden increase of patients. In 2015 the practice had registered 1,200 patients over one weekend from a neighbouring practice that had closed. We saw that the partners demonstrated commitment and dedication to both their patients and the practice team, working tirelessly to continue to provide services. We saw that the lead partner regularly undertook additional home visits early in the mornings or late in the evenings to visit elderly or frail patients of concern to ensure they were supported. Staff told us the partners were approachable and always took the time to listen to all members of staff. The partners, along with the practice manager encouraged a culture of integrity, care and compassion both within their team and towards patients.

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:

# Are services well-led?

Good 

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

- 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. We noted that social events were held regularly for the team.
- We saw that staff were encouraged to support charities through themed days and fundraising opportunities.
- 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 and practice manager. We were told there were good working relations within the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG had been established in 2010 and took an active role in supporting the practice and recommending improvements. For example, the PPG had helped the practice review the telephone system and suggested areas for improvement. We were told by a member of the PPG that the practice was responsive to feedback given and that they felt the PPG made a valued contribution to how the practice operated.

- 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 by the practice on continuous improvement of the quality of care and treatment provided, which meant improved patient outcomes. For example, the practice had worked to reduce unplanned emergency hospital admissions through a Transformation Project Pilot, successfully reducing unplanned admissions within their patient population.

The practice recognised the challenges it had faced with staff changes and shortages and the difficulties patients had experienced in accessing appointments. We saw that the practice demonstrated resilience and were proactive in trying to overcome these challenges. For example through securing long term locum GPs, a long term locum nurse and through the expansion of their nursing team and upskilling of staff to improve accessibility. Despite the difficulties the practice had experienced they continued to accept new patients and we saw evidence of future planning to increase the clinical space available to improve capacity. The practice was also being supported by the Milton Keynes Clinical Commissioning Group and NHS England to secure additional funding whilst they continued efforts to stabilise their clinical team.

The practice had recognised existing challenges and potential future threats to its financial security and ability to continue providing services. In response the practice joined a federation known as Roundabout Health. (A federation is the term given to a group of GP practices coming together in collaboration to share costs and resources or as a vehicle to bid for enhanced services contracts). Through collaborative working with other practices in the federation the practice had been able to secure its future.