Care Quality Commission

Whaddon House Surgery

Quality Report

Whaddon Medical 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	Outstanding
Are services safe?	**Good**
Are services effective?	**Outstanding**
Are services caring?	**Outstanding**
Are services responsive to people's needs?	**Outstanding**
Are services well-led?	**Outstanding**

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 Whaddon House Surgery on 2 August 2016. Overall the practice is rated as **outstanding**.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice had pioneered services to deliver point of care testing (POCT) for D-Dimer and BNP across the locality. (D-dimer tests are used to rule out the presence of a blood clot and BNP tests help with early diagnosis of heart failure).
- Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility, choice and continuity of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, all patients suffering from COPD were invited to join the Milton Keynes Pulmonary Maintenance Group (a support group initiated by the respiratory lead GP at the practice). In addition the practice hosted the local 'Breathe Easy Group' meetings which provided support and educational talks for patients with COPD.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice employed an innovative use of technology to provide services to its patients.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.

Summary of findings

- The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together across all roles.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw several areas of outstanding practice including:

- The practice had invested considerably in the provision of the Community Cardiology service which had many positive outcomes for patients in the locality. For example, they had pioneered services to provide point of care testing (POCT) for Troponin T testing which was used for patients presenting with chest pain in the surgery. An audit demonstrated that up to 88% of potential emergency hospital admissions were avoided through the use of these tests.
- In collaboration with the PPG the practice facilitated regular patient education evenings led by a member of the clinical team or a guest speaker. These sessions were used as an opportunity to provide information on a range of general health topics as well as dedicated evenings for specific groups. The practice demonstrated a commitment to supporting vulnerable patients in their population, developing initiatives with the support of the PPG to work compassionately with patients who may be isolated. For example, in 2013, with the support of the local Community Safety Officer and the PPG, the practice had developed a group known as 'Living in the Moment', focused on reaching out to patients who may have become isolated.
- The practice had purchased a number of Sleep Apnoea testing monitors to support patients presenting with sleep problems. Monitors were fitted by trained health care assistants and patients returned the following day to see the GP for results to be analysed. If required the patient would be referred on to the Oxford Sleep Clinic for further investigations. Providing testing in house reduced the need for patients to be seen in secondary care locally before referral to a specialist facility in Oxford. The practice demonstrated a reduction in referrals of 70% for the period May 2014 to July 2016. Patients not referred received further support from the practice to ascertain and treat the underlying causes of their sleep difficulties, for example, poor chronic disease management.

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 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 systems in place to protect patients from the risks associated with medicines management and infection control.

Are services effective?

The practice is rated as outstanding for providing effective services.

Outstanding

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. For example, the lead GP for respiratory care at the practice had been involved in developing NICE guidelines for asthma care and had introduced advanced asthma testing known as FENO (Fractional Exhaled Nitric Oxide) testing into the practice in August 2013. This identified inflammation of the lung which helped to diagnose new asthma patients and also to identify when complex patients required more support. We saw that since October 2014, 210 patients had received this testing.

- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

We observed a strong patient-centred culture:

- Staff were motivated and inspired to offer kind and compassionate care.
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We found positive examples to demonstrate how patient's choices and preferences were valued and acted on.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- In collaboration with the PPG the practice facilitated regular patient education evenings led by a member of the clinical team or a guest speaker. These sessions were used as an opportunity to provide information on a range of general health topics as well as dedicated evenings for specific groups.
- The practice demonstrated a commitment to supporting vulnerable patients in their population, developing initiatives with the support of the PPG to work compassionately with patients who may be isolated. For example, in 2013, with the support of the local Community Safety Officer and the PPG the practice had developed a group known as 'Living in the Moment', focused on reaching out to patients who may have become isolated.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

Summary of findings

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, all patients suffering from COPD were invited to join the Milton Keynes Pulmonary Maintenance Group (a support group initiated by the respiratory lead GP at the practice). In addition the practice hosted the local 'Breathe Easy Group' meetings which provided support and educational talks for patients with COPD.
- There were innovative approaches to providing integrated patient-centred care. For example, the practice had invested considerably in the provision of the Community Cardiology service which had many positive outcomes for patients in the locality. They had pioneered services to provide point of care testing (POCT) for Troponin T testing which was used for patients presenting with chest pain in the surgery. An audit demonstrated that up to 88% of potential emergency hospital admissions were avoided through the use of these tests.
- The practice had purchased a number of Sleep Apnoea testing monitors to support patients presenting with sleep problems. Monitors were fitted by trained health care assistants and patients returned the following day to see the GP for results to be analysed.

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- Practice staff reviewed the needs of its local population and engaged with the NHS
- Patients said they were able to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- A Phlebotomy clinic ran daily enabling patients to have blood tests conducted locally rather than at the local hospital

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

Outstanding

Summary of findings

- The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together across all roles.
- The management at the practice regularly reviewed and discussed services and future plans with staff to encourage a fully engaged and motivated practice team.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- The practice had a well-structured meetings system which covered all recommended areas.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice gathered feedback from patients and it had a very engaged patient participation group (PPG) which influenced practice development. For example, the PPG had actively supported many of the practice's community initiatives such as the walking group, living in the moment scheme and patient education evenings.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- There was a strong focus on continuous learning and improvement at all levels.
- The practice demonstrated clinical innovation, for example through the vast array of additional services it provided. It had been at the forefront of developments to clinical services for the locality and was committed to diversifying services available in primary care.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had developed a group known as 'Living in the Moment', focused on reaching out to patients who may have become isolated for an array of reasons, including bereavement or retirement.
- The practice supported frail elderly patients in local nursing and residential homes. In addition, the practice provided 'elderly peoples assessments', a programme developed in 2014 to support patients over the age of 75 years to ensure they were receiving support and information on services available. The target group for the practice were referred to as 'hidden patients', who had not attended the practice for over 12 months.
- The practice provided influenza, pneumonia and shingles vaccinations.
- A phlebotomy clinic ran daily enabling patients to have blood tests conducted locally rather than at the local hospital.
- The practice offered health checks for patients over the age of 75.
- Between January 2015 and July 2016 the practice had completed 571 of the 928 (62%) eligible health checks for people aged 75 years and over.
- All patients over the age of 75 had a named GP.
- Since 2014, the practice had been providing GP services to a local nurse led intermediate care unit providing rehabilitation for frail elderly patients. Staff told us that this had enabled the practice to increase their knowledge of elderly care and enabled them to provide better care for their patients.

People with long term conditions

Outstanding

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

- GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

- The practice offered a Community Cardiology service, developed in 2004, for the practice population and those across Milton Keynes and parts of Bedfordshire. We saw evidence that the practice had invested heavily in developing this service, ensuring they were at the forefront of technology and expertise to provide the best possible outcomes for patients.
- The practice had pioneered services to deliver 'point of care testing' (POCT) for D-Dimer and BNP. (D-dimer tests are used to rule out the presence of a blood clot and BNP tests help with early diagnosis of heart failure).
- 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 was 76%, where the CCG average was 74% and the national average was 78%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- All patients suffering from COPD were invited to join the Milton Keynes Pulmonary Maintenance Group (a support group initiated by the respiratory lead GP at the practice). In addition the practice hosted the local 'Breathe Easy Group' meetings which provided support and educational talks for patients with COPD.
- The practice was involved in a pilot scheme with the British Lung Foundation (BLF) to improve the respiratory function of patients with COPD. The practice had written to a specific group of patients encouraging them to attend a local 12 week programme to improve their diet and lifestyle in an effort to improve their health.
- In corroboration with the PPG the practice facilitated regular patient education evenings led by a member of the clinical team or a guest speaker. These sessions were used as an opportunity to provide information on a range of general health topics as well as dedicated evenings for specific groups, including those suffering from long term conditions such as asthma and diabetes.
- The lead GP for respiratory care at the practice had been involved in developing NICE guidelines for asthma care and had introduced advanced asthma testing known as FENO (Fractional Exhaled Nitric Oxide) testing into the practice. This

identified inflammation of the lung which helped to diagnose new asthma patients and also to identify when complex patients required more support. We saw that since October 2014, 210 patients had received this testing.

Families, children and young people

Outstanding

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 83%, which was comparable to the CCG average and national averages of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- Family planning and contraceptive advice was available.
- The practice had developed a highly successful walking group. We were told that the group regularly raised funds for a local school for children with learning disabilities. Two of the children were also able to participate in some walks.
- The practice provided Primary Care Outpatient Clinics (PCOCs) which enabled patients to receive care they would normally receive in secondary care at Whaddon House Surgery. At the time of our inspection the practice were able to offer PCOC clinics for respiratory, dermatology and gynaecology each of which was led by a GP with Specialist interest (GPwSI) from within the existing practice team (with an external Consultant gynaecologist supporting the gynaecology clinic). We saw evidence that in the 12 months preceding our inspection a total of 988 patients, who would otherwise have been referred to secondary care, had received care at the practice (395 for dermatology, 118 for respiratory and 475 for gynaecology).

Working age people (including those recently retired and students)

Outstanding

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice provided health checks to all new patients and carried out routine NHS health checks for patients aged 40-74 years.
- The practice was committed to improving the health and lifestyle of its patients and we saw that they worked collaboratively with the a local football team to provide wellbeing assessments for patients under the age of 40 years with a body mass index (BMI) higher than 30. The assessment included both health and lifestyle measurements and patients were signposted to a range of exercise facilities. Coaches then provided ongoing support to patients to help them achieve their weight loss goals.
- Pre-bookable appointments were available from 7am on Tuesdays, Wednesdays and Thursdays.
- The practice had enrolled in the Electronic Prescribing Service (EPS). This service enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.
- A HIV quick test was available for all new patients registering at the practice (that met specified criteria). This had been developed by the practice and others within the locality in response to public health concerns.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group. The practice website was fully managed by an external company ensuring patients always had access to up to date information.

People whose circumstances may make them vulnerable

Outstanding

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice held palliative care meetings in accordance with the national Gold Standards Framework involving district nurses, GP's and the local MacMillan Hospice nurses.

- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice had identified 2.5% of the practice list as carers. The practice made efforts to identify and support carers in their population. A member of staff had been trained as Carers Champion.
- The practice demonstrated a commitment to supporting vulnerable patients in their population, developing initiatives with the support of the PPG to work compassionately with patients who may be isolated. For example, in 2013, with the support of the local Community Safety Officer and the PPG the practice had developed a group known as 'Living in the Moment', focused on reaching out to patients who may have become isolated.
- The practice had established a successful walking group in 2011, with the support of the PPG and a retired member of staff. At the time of our inspection there were over 100 people participating in these walks each week, not only providing valuable health benefits but equally enabling participants to develop social relationships and engage in the community.
- The practice was working with Milton Keynes Cancer Patient Partnership (MKCPP) to develop a group called 'Cancer and Beyond' aimed at supporting people recovering from Cancer once they had been discharged from hospital or other clinical services.
- The practice provided regular ward rounds at a local residential rehabilitation centre for patients with an acquired brain injury to ensure that both staff and patients at the centre are well supported.

People experiencing poor mental health (including people with dementia)

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

Outstanding

- Staff had a good understanding of how to support patients with mental health needs and dementia. We saw that all staff had undergone additional training to become dementia friends.
- Performance for mental health related indicators were comparable to local and national averages. For example, the percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 94% where the CCG average was 86% and the national average was 88%.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice worked with the Memory Assessment Service in 2015 to support patients identified as at risk of memory loss.
- The practice had told patients experiencing poor mental health about how to access various 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.
- In corroboration with the PPG, the practice facilitated regular patient education evenings. These sessions were used as an opportunity to provide information on a range of general health topics as well as dedicated evenings for specific groups. We saw that a session entitled 'Mental Health Matters' was being planned for September 2016, to specifically support patients suffering from poor mental health.
- The practice had developed a self-help leaflet for patients experiencing poor mental health which provided a directory of support resources .The practice had also purchased some self-help books which could be given out or loaned to patients.
- All staff had received 'Dementia friends' training to help them support patients appropriately.

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 largely in line with local and national averages. 249 survey forms were distributed and 119 were returned. This represented a response rate of 48% (less than 1% of the practice's patient list).

- 47% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 60% and national average of 73%.
- 76% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and national average of 76%.
- 72% of patients described the overall experience of this GP practice as good compared to the CCG average of 79% and national average of 85%.
- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 71% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 21 comment cards of which 20 were positive about the standard of care received. Comments referred to staff as caring, helpful and polite. Doctors were described as respectful and always ready to listen to patient concerns.

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

The practice also sought patient feedback by utilising the NHS Friends and Family test. The NHS Friends and Family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. Results from May 2015 to May 2016 showed that 77% of the 164 patients who had responded were either 'extremely likely' or 'likely' to recommend the practice.

Whaddon House Surgery

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 Whaddon House Surgery

Whaddon House Surgery, also known as Whaddon Medical Centre provides a range of primary medical services, including minor surgical procedures from its location on Witham Court, Tweed Drive on the outskirts of Bletchley, Milton Keynes.

The practice serves a predominantly White British population of approximately 12,400 patients, with an average age range. National data indicates the area is one of mid deprivation in comparison to England as a whole.

The clinical team consists of three male and three female GP partners, two salaried GPs (one male and one female), a physiologist, a pharmacist, four practice nurses; two of whom were Independent Prescribers and five health care assistants. The team is supported by a practice manager, an assistant practice manager and a team of administrative staff. The practice holds a General Medical Services (GMS) contract for providing services, which is a nationally agreed contract between general practices and NHS England for delivering general medical services to local communities.

The practice is a training practice with three accredited GP trainers. The practice was due to receive its new intake of trainees on the day after our inspection.

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

Whaddon House Surgery is open between 8am and 6.30pm Monday to Friday. In addition, pre-bookable appointments are available from 7am on Tuesdays, Wednesdays and Thursdays. The practice was also part 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.

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.

Detailed findings

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 2 August 2016.

During our inspection we:

- Spoke with a range of staff including three GP partners, a practice nurse, a health care assistant, the practice manager and deputy practice manager.
- We spoke with patients who used the service.
- Observed how staff interacted with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, an explanation, a written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, we saw that when a patient was issued with incorrect medication, the practice were prompt to investigate, apologise to the patient and improve their systems to reduce the risk of recurrence.
- The practice maintained a log of significant events for analysis and they were discussed as a standing item on the agenda for practice meetings, to ensure that lessons learnt were shared and monitored.

We reviewed safety records, incident reports, MHRA (Medicines and Healthcare products Regulatory Agency) alerts, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons learnt were shared and action was taken to improve safety in the practice. For example, we saw that when an alert was received regarding a batch of tests pots used for cervical smear samples a search was undertaken within the practice by an appropriate member of staff and all affected pots were removed from use as recommended in the alert.

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 GP lead for safeguarding, supported by another GP acting as deputy lead. 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 in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention team to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, we saw that procedures for managing sharps boxes were updated following an audit to ensure they were always signed and dated as required.
- 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. GPs were responsible for ensuring that patients taking high risk medicines were receiving appropriate monitoring tests, prior to reauthorisation of prescriptions.
- The practice carried out regular medicines audits, with the support of the Milton Keynes CCG medicines management team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Two of

the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGDs) 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 reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. Fire alarms were tested weekly and the practice had a variety of other risk assessments in place to monitor safety of the premises such as Control of Substances Hazardous to Health (COSHH), infection control and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All electrical equipment was checked annually to ensure the equipment was safe to use and clinical equipment had been checked in January 2016 to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff informed us they worked flexibly as a team and provided additional cover if necessary during holidays and absences.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms 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.

Outstanding

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 ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. For example, the lead GP for respiratory care at the practice had been involved in developing NICE guidelines for asthma care and had introduced advanced asthma testing known as FENO (Fractional Exhaled Nitric Oxide) testing into the practice in August 2013. This identified inflammation of the lung which helped to diagnose new asthma patients and also to identify when complex patients required more support. Clinicians would book appointments for patients in FENO clinics for the test to be undertaken by a health care assistant. The results were then assessed by the GP lead for respiratory conditions who would develop an ongoing management plan for the patient to ensure they were appropriately supported. We saw that since October 2014, 210 patients had received this testing.
- All staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. For example, we saw evidence that following an update to NICE guidance on nutrition advice for patients with chronic obstructive pulmonary disease (COPD) the practice had introduced information leaflets for these patients incorporating updated advice.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available.

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

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

- the percentage of patients with diabetes, on the register, in whom the last blood glucose reading showed good control in the preceding 12 months was 76%, where the CCG average was 74% and the national average was 78%. Exception reporting for this indicator was 5% compared to a CCG average of 13% and national average of 12%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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

- The percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 94% where the CCG average was 86% and the national average was 88%. Exception reporting for this indicator was 11% compared to a CCG average of 18% and national average of 13%.
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness in the preceding 12 months was 91% which was comparable to the CCG average of 88% and national average of 90%. Exception reporting for this indicator was 3% compared to a CCG average of 12% and national average of 11%.

There was evidence of a strong commitment to quality improvement. We saw that audits of clinical practice were undertaken, with 11 audits having been undertaken in the last two years. Examples of audits included:

Outstanding

Are services effective?

(for example, treatment is effective)

- An audit on the success of delayed antibiotic prescribing which highlighted that on average only a third of the post-dated prescriptions were used, demonstrating the practice's changed approach to be effective.
- Findings were used by the practice to improve services. For example, recent action taken as a result included an improvement in monitoring of patients who had suffered from gestational diabetes to ensure they did not develop diabetes post-delivery. This had been undertaken following a review of NICE guidance. Following audit the practice reviewed its procedures to ensure that all post-natal patients were recalled as necessary.
- The practice provided many additional services to its patients not normally found in a GP setting and we saw that on occasion these were developed in response to audits. For example, an audit on referrals had identified the practice to have the highest referral rate for audiology screening in the locality. In response the practice had invested in equipment enabling them to conduct hearing tests themselves as a triage process when assessing the need to refer patients on to secondary care. We saw evidence that an audit of the service demonstrated a significantly reduced referral rate with the practice returning results for referrals in 2016 as one of the lowest across the locality. (A reduction on average of 60%).
- The practice also participated in local audits, national benchmarking, accreditation, peer review and research. For example, as part of the practice's Community Cardiology service they had pioneered services to provide 'point of care testing' (POCT) for Troponin T testing which was used for patients presenting with chest pain in the surgery. An audit was carried out on the service to ascertain its safety and effectiveness. The audit demonstrated that up to 88% of potential emergency hospital admissions were avoided through the use of the tests where patients tested did not demonstrate any adverse clinical outcomes five months later.

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. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example we saw that nursing staff and health care assistants involved in reviewing patients with long term conditions such as diabetes and asthma attended regular updates and received training to support them specifically in these roles.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal in the last 12 months. We saw that the practice encouraged its staff to develop and progress their skills and careers, for example a receptionist had trained as a health care assistant and had undertaken further training to support the community cardiology service provided by the practice.
- We noted that the practice closed one afternoon each month to provide protected learning time for staff.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules, in-house training and training offered by other external providers.
- The practice had three GPs registered as trainers. Registrars and Foundation Year 2 doctors (a foundation doctor is a grade of medical practitioner undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/ general practice training) received regular debriefing after sessions, this acted to both supervise activities and

support development. In 2014 the practice was approved by the Oxford Deanery to develop a specialised placement scheme for a trainee to be a Community Registrar, encompassing advanced training in cardiology, respiratory and diabetes care.
- From 2011, following recognition of the pressures and complex decisions doctors often faced in isolation the practice had developed what they referred to as a weekly 'Clinical Tea Party'. Although these meetings were minuted, this was an informal group session providing an opportunity to share difficult cases and brainstorm on potential diagnosis and problem solving. Often discussions centred on the practice's most vulnerable patients. These meetings were held in addition to formal weekly managerial and clinical meetings.

Coordinating patient care and information sharing

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

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their computer system. This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs along with assessment and planning of ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. The practice held a register of patients at risk of unplanned hospital admission or readmission. We saw that patients on this register and any others who had been recently admitted or discharged from hospital were discussed at monthly clinical meetings when needed. They benefitted from focussed support which included priority access if required. At the time of our inspection there were 185 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 (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. These patients also had access to what the practice referred to as a 'PA Service', which enabled them to use a disclosed code when contacting the practice to ensure that they received an immediate response to requests for appointments, home visits or prescription requests. At the time of our inspection six patients were receiving this care.
- The practice held regular safeguarding meetings, attended by GPs, the practice nurse and health visitor. Records were kept of discussions and action taken in relation to children at risk. Information from other agencies involved in safeguarding was also shared during these meetings.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Written consent forms were used for specific procedures as appropriate.

Supporting patients to live healthier lives

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

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- A practice nurse with additional training provided smoking cessation advice to patients with the option to refer patients to local support groups if preferred.
- GP leads were appointed for all chronic diseases. They worked with nurses trained in chronic disease management to support patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).
- All patients suffering from COPD were invited to join the Milton Keynes Pulmonary Maintenance Group (a support group initiated by the respiratory lead GP at the practice). In addition the practice hosted the local 'Breathe Easy Group' meetings which provided support and educational talks for patients with COPD.
- The practice was involved in a pilot scheme with the British Lung Foundation (BLF) to improve the respiratory function of patients with COPD. The practice had written to a specific group of patients encouraging them to attend a local 12 week programme to improve their diet and lifestyle in an effort to improve their health.
- The practice worked with the Memory Assessment Service in 2015 to support patients identified as at risk of memory loss. Patients were contacted to assess whether there were concerns which would warrant further investigation. As a result 66 patients were assessed and each patient was coded as red, amber or green depending on their screening result. Patients coded as red were referred for a further assessment at the hospital Memory Assessment clinic.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG and the national averages of 82%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening, similarly following up patients who failed to attend their screening appointments. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

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 86% to 98% and five year olds from 89% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, patients over 75 years old and NHS health checks for patients aged 40–74 years. At the time of our inspection for the period October 2012 to July 2016 the practice had completed 1,823 of 5,243 (35%) eligible health checks for people aged 40 to 74 years. Between January 2015 and July 2016 the practice had completed 571 of the 928 (62%) eligible health checks for people aged 75 years and over. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding

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 21 patient Care Quality Commission comment cards we received 20 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. Three cards commented on difficulty accessing appointments although did proceed to comment that reception staff were always helpful and did their best to accommodate requests.

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

The practice demonstrated a commitment to supporting vulnerable patients in their population, developing initiatives with the support of the PPG to work compassionately with patients who may be isolated. In 2013, with the support of the local Community Safety Officer and the PPG the practice had developed a group known as 'Living in the Moment', focused on reaching out to patients who may have become isolated for an array of reasons, including bereavement or retirement. This group provided social support and access to information on support groups and activities. We were told that the initiative had proven to be very popular acting as a gateway to social interaction and support for some isolated patients, enabling them to engage socially in an environment they could trust. At the time of our inspection approximately 20 people were being supported by this initiative.

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 above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% 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%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 91% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and the national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 80% 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 had a stable workforce with many long standing members of staff. We were told that staff and patients were familiar with each other which was beneficial to the practice's aim to provide compassionate care as staff were often able to recognise patients needs and appointment requirements.

We witnessed a strong patient centred culture with a focus on providing continuity of care and excellent service to patients. We saw evidence that the practice was well regarded within the local community and made efforts to support and engage with its local population. For example, the practice had established a walking group in 2011, with the support of the PPG and a retired member of staff. At the time of our inspection there were over 100 people participating in these walks each week, not only providing valuable health benefits but equally enabling participants to develop social relationships and engage in the community. We were told that the group regularly stopped

Are services caring?

at a local school for children with learning disabilities to enjoy refreshments made by the children. Two of the children were also able to participate in some walks. The group had undertaken numerous walks for charity, raising money for the school and other local organisations. The University of East Anglia had also conducted studies into the success of the group and its benefits.

Care planning and involvement in decisions about care and treatment

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

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

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 82%.
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format and different languages if required.
- A hearing loop was available for patients who suffered from impaired hearing.

Patient and carer support to cope emotionally with care and treatment

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

In corroboration with the PPG the practice facilitated regular patient education evenings led by a member of the clinical team or a guest speaker. These sessions were used as an opportunity to provide information on a range of general health topics as well as dedicated evenings for specific groups. For example we saw that a session entitled 'Mental Health Matters' was being planned for September 2016, to specifically support patients suffering from poor mental health. Sessions were advertised on the practice website and newsletter to encourage attendance.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 312 patients as carers (2.5% of the practice list). One of the GPs was particularly dedicated to identifying unknown carers and supporting them. A member of staff had trained as Carers Champion and was able to signpost patients to suitable support organisations. A noticeboard in the waiting room also provided written information to direct carers to the various avenues of support available to them.

We saw that the PPG had written articles in the practice newsletter asking carers to identify themselves to the practice. Once identified as a carer patients were offered a physical health check at the practice and signposted to the services offered by the local support organisation Carers MK.

The practice was working with Milton Keynes Cancer Patient Partnership (MKCPP) to develop a group called 'Cancer and Beyond' aimed at supporting people recovering from Cancer once they had been discharged from hospital or other clinical services. In particular they aimed to provide support on returning to work, financial concerns and emotional support in coming to terms with difficult periods of illness. If successful it was envisaged that this initiative would be offered across the locality. Although still in its early stages we received positive feedback on one of the CQC comments cards from a patient recovering from cancer who had received a questionnaire from the practice in relation to the scheme.

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Families experiencing a new birth were also sent a card from the practice.

The practice was also keen to support patients struggling with drug misuse, who they recognised as often being chaotic and vulnerable. We saw that these patients, once identified, were discussed at weekly clinical meetings and a clinician was identified to provide continuity of care. In addition a buddy clinician was allocated to ensure the patients' needs were met as far as possible. The patient was then informed of their allocated GP and the administrative team were updated to ensure that these patients were able to access urgent appointments and telephone support when needed. We were told that providing this continuity of care alongside urgent access had proven an effective method of supporting these patients.

Mental health was another area of focus for the practice. They had recognised that trainees often struggled with this area due to lack of exposure and provided additional tutorials to develop their knowledge during their placements at the practice to improve patient care. The practice had developed a self-help leaflet for patients which provided a directory of support resources .The practice had also purchased some self-help books which could be given out or loaned to patients. In addition all staff had received 'Dementia friends' training to help them support patients appropriately.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice offered a community cardiology service, developed in 2004, for its patients and those across Milton Keynes and parts of Bedfordshire. We saw evidence that the practice had invested in developing this service, ensuring they were at the forefront of technology and expertise to provide the best possible outcomes for patients. The service was led by four GPs with specialist interest (GPwSIs) and a full-time physiologist, supported by the five health care assistants and a dedicated team of administrative staff. The practice received 70% of all Milton Keynes cardiology referrals. In the 12 months prior to our inspection the practice had provided services to 2,299 patients registered at other practices and 121 patients from their own practice.

In addition the practice worked in collaboration with the CCG to offer patients access to three outpatient clinics. These clinics were referred to as Primary Care Outpatient Clinics (PCOCs) and enabled patients to receive care they would normally receive in secondary care at Whaddon House Surgery. At the time of our inspection the practice were able to offer PCOC clinics for respiratory, dermatology and gynaecology each of which was led by a GPwSI from within the existing practice team (with an external Consultant gynaecologist supporting the gynaecology clinic). Staff told us they had seen a positive response and that the locality had benefitted from the service as pressures on secondary care for these services had been relieved.

The practice was committed to the NHS England plan to bring treatment out of secondary care where possible and into the community. Staff informed us that the practice maintained low figures for the proportion of its patients referred to secondary care and this was largely due to efforts made by the practice to provide additional services to its patients. We saw evidence that in the 12 months preceding our inspection a total of 988 patients, who would otherwise have been referred to secondary care, had received care at the practice (395 for dermatology, 118 for respiratory and 475 for gynaecology).

As part of the community cardiology service the practice had pioneered services to provide point of care testing (POCT) for NT-BNP (for the early diagnosis of heart failure), D-dimer (used to rule out the presence of a blood clot) and Troponin T (for patients presenting with chest pain). Following the initial pilots the POCT services for BNP and D-Dimer testing were available to patients across the locality via a hub and spoke model developed by the practice team. In the twelve months preceding our inspection the practice had offered this service to a total of 509 patients providing over 60% of the overall POCT service for BNP and D-Dimer testing for the locality. At the time of our inspection the practice were piloting the use of POCT to provide CRP testing in an effort to reduce inappropriate antibiotic prescribing. (CRP is an acronym for C-reactive protein which is a blood test marker for inflammation in the body and often used as an indicator of infection).

- The practice provided 'early bird' clinics on Tuesday, Wednesday and Thursday mornings from 7am for patients who could not attend during normal opening hours.
- 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 offered phlebotomy services Mondays to Fridays.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice offered a dedicated hearing test service, with checks carried out by a health care assistant before analysis by a GP.
- 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 supported frail elderly patients in local nursing and residential homes. In addition the practice provided elderly peoples assessments, a programme developed in 2014 to support patients over the age of 75

years and ensure they were receiving support and information on services available. The target group for the practice were what they referred to as 'hidden patients' who had not attended the practice for over 12 months. These patients were seen in their homes or at the practice as convenient to them.

- The practice ran an anticoagulant clinic for patients to monitor their treatment. (Anticoagulants are medicines used to prevent blood from clotting). At the time of our inspection the practice offered this service to over 200 patients and was well received by patients as it reduced the need for them to travel to secondary care for the service.
- The practice had purchased a number of Sleep Apnoea testing monitors to support patients presenting with sleep problems. Monitors were fitted by trained health care assistants and patients returned the following day to see the GP for results to be analysed. If required the patient would be referred on to the Oxford Sleep Clinic for further investigations. Providing testing in house reduced the need for patients to be seen in secondary care locally before referral to a specialist facility in Oxford. The practice demonstrated a reduction in referrals of 70% for the period May 2014 to July 2016. Patients not referred received further support from the practice to ascertain and treat the underlying causes of their sleep difficulties, for example, poor chronic disease management.
- The practice provided regular ward rounds at a local residential rehabilitation centre for patients with an acquired brain injury to ensure that both staff and patients at the centre are well supported.
- Since 2014 the practice had been providing GP services to a local nurse led intermediate care unit providing rehabilitation for frail elderly patients. Staff told us that this had enabled the practice to increase their knowledge of elderly care and enabling them to provide better care for their patients.
- A HIV quick test was available for all new patients registering at the practice (that met specified criteria).

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. In addition, pre-bookable appointments were available from 7am on Tuesdays, Wednesdays and Thursdays. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The practice had also joined the local 'Prime Ministers Challenge fund' (PMCF) collaboration called MKExtra, enabling their patients, wishing to be seen outside of the practice's extended and core hours, to receive routine GP care at a network of practices across the locality.

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

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

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 47% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% and the national average of 73%.

The practice was aware of these lower scores and we saw that they discussed the results in practice meetings and developed action plans to improve. We saw that the early bird clinics had been developed in an effort to improve access and that additional staff were tasked with answering phones during peak periods. The practice carried out its own surveys and was making continued efforts to educate patients on alternative methods of appointment booking. The practice was in an area experiencing high residential development and staff informed us that as their access was improving so too was the demand for their services. We were told of plans to expand the practice and were shown the site earmarked to house the expansion. The practice had developed a strong reputation locally and this had also led to an increase in demand for services. People told us on the day of the inspection that they were able to get appointments when they needed them. Three comments cards received did comment on difficulty accessing appointments at times but patients also commented that reception staff always made efforts to accommodate patient requests as far as possible.

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.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Patients were able to telephone the practice to request a home visit and a GP would call them back to make an assessment and arrange the home visit appropriately. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

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

We looked at 28 complaints received between April 2015 and March 2016 and found they had been dealt with in an open and timely way. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. Patients received an explanation of events and investigations and a written apology if required from the practice. We noted that the practice did not maintain a log of verbal complaints and staff informed us these were dealt with as they occurred. The practice informed us that they would maintain a log of verbal complaints in the future.

Are services well-led?

Outstanding

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

Our findings

Vision and strategy

The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together across all roles. The management at the practice regularly reviewed and discussed services and future plans with staff to encourage a fully engaged and motivated practice team.

GP partners and managers were able to discuss the plans for the future and we saw evidence of regular partners meetings that were held, incorporating discussions around future planning. We saw evidence of forward thinking to maintain the smooth running of the practice and ensure patient care was not compromised. For example, the practice had recognised the increasing demand for its services and the plans for extensive housing development locally. In light of this we saw that the practice had earmarked an area for extension to ensure the service could remain stable.

Governance arrangements

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

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

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

Leadership and culture

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

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

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

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

- Staff told us that there was a high level of constructive engagement between the practice leadership and with staff and a high level of staff satisfaction.
- Staff told us the practice held regular team meetings. We saw evidence of minutes and agendas for these, which included GP partners meetings, management meetings, clinical meetings, palliative care meetings, multi-disciplinary meetings with other health

professionals and all staff meetings. Staff meetings were held monthly and every member of staff was invited. Staff could add items to the agenda prior to the meetings.

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team social events were held throughout the year.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. We spoke with a member of the PPG who told us that the practice was very responsive to any points raised. We saw evidence of strong collaborative working between the PPG and the practice. For example, the PPG had actively supported many of the practice's community initiatives such as the walking group, living in the moment scheme and patient education evenings.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

The training and research practice had three GP trainers supporting their trainees. The practice also helped to train student nurses and health care assistants. Practice GPs also had lead roles outside of the practice in the CCG and other health organisations which helped them to deliver the most up to date care to their patients. GPs with specialist interest (GPwSI) had lead roles in respiratory, cardiology, dermatology and gynaecology which provided access for patients to near to home expertise rather than attend local hospitals for their diagnosis.

The practice actively participated in research to enable positive patient outcomes. This included involvement in research study on sleep apnoea, kidney failure and numerous other areas.

The practice demonstrated clinical innovation, for example through the vast array of additional services it provided. It had been at the forefront of developments to clinical services for the locality and was committed to diversifying services available in primary care. Alongside this commitment was an awareness of safety and the practice demonstrated its extensive research and auditing of services to ensure they were safe and promoted good outcomes for patients. For example, the cardiovascular services provided by the practice were audited comprehensively and we saw that the practices findings and research were shared at international platforms as examples of good practice.

The practice used NICE guidelines to positively influence and improve practice and outcomes for patients. For example, the lead GP for respiratory care at the practice had been involved in developing NICE guidelines for asthma care and had introduced advanced asthma testing known as FENO (Fractional Exhaled Nitric Oxide) testing into the practice in August 2013. This identified inflammation of the lung which helped to diagnose new asthma patients and also to identify when complex patients required more support. We saw that since October 2014, 210 patients had received this testing.

The practice was not only keen to share their knowledge and expertise with other practices locally but was focused on smarter ways of working through liaison with other practices in the area to improve outcomes for patients. For example, the practice had pioneered services to deliver point of care testing (POCT) for D-Dimer and BNP. (D-dimer tests are used to rule out the presence of a blood clot and BNP tests help with early diagnosis of heart failure). The

practice was also piloting POCT for CRP in an effort to reduce inappropriate antibiotic prescribing. (CRP is an acronym for C-reactive protein which is a blood test marker for inflammation in the body and often used as an indicator of infection).

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.