Asplands Medical Centre

Inspection 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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as good overall. This is the third inspection of Asplands Medical Centre. At our last inspection on 8 December 2016, the practice was rated as good for providing safe services and good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Asplands Medical Centre on 21 June 2018 as part of our inspection programme.

At this inspection we found:

- The practice had sustained and continued to improve the high level of achievement since the last inspection, and had further improved in areas including caring, responsiveness and well led.
- Learning identified from our previous inspection in June 2016 had been shared with the Clinical Commissioning Group (CCG) and changes had been made to improve medicine systems in other practices.
- The practice had a highly effective and well managed quality improvement process in place to identify where they might improve. They had a continuous programme of audits and there was a cohesive practice approach to improvement. The practice performance in relation to the quality and outcome framework (QOF) was above the CCG and national average and exception reporting was below the CCG and national average.
- The strong leadership, embedded governance structure and culture were used to drive and improve the delivery of high-quality person-centred care. All staff were involved in the development of the practice and were proud of their achievements.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. Staff ensured that care and treatment was delivered according to evidence- based guidelines.
- The national GP patient satisfaction data although statically comparable was consistently above the local and national averages for outcomes on the National GP Patient Survey published in July 2017. Some areas were higher than the January 2016 data. Patients reported they were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. There were several examples of where the practice had gone the extra mile for patients.
- Generally, patients found the appointment system easy to use and reported that they could access care when they needed it.
- Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility, choice and continuity of care. The practice understood the needs of the services users and regularly engaged in the local community.
- The practice had been responsible for setting up and continuing to support additional services that benefitted their patients.
- Care provided was reflective of the needs of the population including those who worked on the nearby safari park and the small population of travellers.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw areas of outstanding practice:

- We saw that the practice provided support to victims of human trafficking; they opened outside normal practice hours to provide this service. The practice had continued to work with other agencies such as the police and offered to provide care for those that require services outside of the usual core GP services.
- The practice had over many years brought various services to the practice to benefit patients and to save them travelling to other clinics or hospital some distant away. These services included aural care, wound care and physiotherapy. They had worked and engaged with the local community and voluntary agencies ensuring their patients benefit from the support that was available including transport and support for patients who had suffered or who were receiving treatment for cancer.

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, a practice nurse specialist adviser and a member of CQCs medicines management team.

Background to Asplands Medical Centre

Asplands Medical Centre provides a range of primary medical services from its semi-rural location at Asplands Close, Woburn Sands in Bedfordshire. The practice has a branch surgery, known as the Woburn Surgery on Eleanor Close, Woburn in Bedfordshire. There is a dispensary at the main practice and the branch surgery that provides medicine for patients who live more than one mile from a pharmacy. As part of this inspection we visited both sites.

The provider is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury. These are delivered from both sites.

Asplands Medical Centre is situated within the NHS Bedfordshire Clinical Commissioning Group (CCG) and provides services to 11,638 patients under the terms of a general medical services (GMS) contract. This is a contract between general practices and NHS England for delivering services to the local community.

There are three female GP partners, three male GP partners and one female salaried GP. There are six practice nurses, two health care assistants and two phlebotomists. These are supported by a practice manager (who is also a partner in the practice) and an experienced team of reception/administration staff. Four dispensers support the dispensary manager. The practice is a training practice, with three trainers and a whole practice team approach to educating GP registrars and Medical students.

The area has a higher than average number of patients aged of 65 and over, and fewer patients aged under 18 years old than the national average. The National General Practice Profile states that 93% of the practice population is from a white background with 7% of the population originating from black, Asian, mixed or other non-white ethnic groups. The practice has a small population of travellers

Information published by Public Health England, rates the level of deprivation within the practice population group as ten, on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. However, the practice does serve areas of deprivation, to vulnerable groups such as travellers and homeless people.

Outside of practice opening hours, patients are directed to the local out of hours service through NHS 111.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The practice reduced the risks to patients by holding personal GP lists and covering each other for holiday.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- The practice provided enhanced services in the managing of emergencies. The practice undertook specialist tests, D-Dimer, and cardiac troponin monitoring. One of these tests is used to help rule out the presence of a blood clot.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results, each GP had a buddy to ensure all results were dealt with in a timely way and by a GP who knew the patient.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Arrangements for dispensing medicines at the practice kept patients safe.

Track record on safety

The practice had a good track record on safety.

Good

Are services safe?

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and acted to improve safety in the practice and shared learning with others such as the clinical commissioning group (CCG) and other practices.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.
- The practice had shared their learning from the findings of the previous CQC inspection (in June 2016) in relation to the management of controlled drugs. They had shared this with the CCG and as a result other practices have reviewed and amended their systems and processes.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice, and all the population groups as good for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- The practice maintained personal GP lists ensuring patients had continuity of care. Each GP had a buddy to cover in times of absence. This ensured the patients usually saw or spoke to a GP who knew them well.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions in the records we viewed.
- The practice had a blood pressure monitoring machine, a height measure and weighing scales available in the waiting area. This enabled patients who wished to monitor their own health between routine follow up appointments to do so. The information was added to the patient clinical records.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people;

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice set up a complex wound care service to ensure the patients had access to wound care closer home and did not have to travel the community clinics 30 miles away. They provided the nursing team with the extended training, additional appointment time and specialist equipment. This had been a factor in the practice having the lowest A+E attendance figures in the CCG.
- The practice set up and continues to support the voluntary transport scheme for older patients to attend the practice and a voluntary delivery service for medicines to house bound patients.
- The practice hosted and brought community services such as NHS podiatry and physiotherapy into the practice enabling patients to be seen in the practice rather than travelling to the community setting.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, the practice nurses had received additional training in order to start and monitor patients using injections to manage their diabetes.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).
- The practice provided a blood monitoring machine, height measure and weighing scales for patients to self-monitor their conditions.
- The practice's performance on quality indicators for long term conditions was in line with or above the local and national averages.

Families, children and young people:

Good

Are services effective?

Childhood immunisation uptake rates were in line with the target percentage of 90% or above. The percentage for children aged under two was slightly under the 90%. The practice took immediate action and investigated the lower figure.

- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. We saw evidence where this had been effectively managed in conjunction with a safeguarding event.
- The practice provided teenage cards for young people who use these to get an immediate appointment with the clinician of their choice. The practice told us that this had increased the number of young people accessing the services and had increased their performance figures for conditions such as asthma reviews for young people as they were able to do opportunistic health checks. The practice had achieved a performance of 100% for Asthma in relation to the quality and outcome framework.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 79%, which was above the CCG average of 74% and the national average of 72% and in line with the 80% coverage target for the national screening programme.
- The practice's uptake for breast screening was 82% which was higher than the CCG average of 71% and the national average of 70%.
- The practice uptake for bowel cancer screening was higher than the CCG average the national average.
- The practice had a system to follow up any patient who had concerns or had not attended the screening appointment. The practice told us that they believed this had resulted in the practice uptake for bowel cancer screening being higher than the CCG average the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice offered these and clinics such as smoking cessation appointments on Saturday mornings.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Care home staff we spoke with told us that the GPs were very supportive to patients, relatives and staff during these difficult times.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice highlighted patients that were undertaking treatments such as chemotherapy ensuring reception gave timely appointments and appropriate waiting areas and support.
- The practice told us that the weekly clinical governance and multidisciplinary meetings (MDT) enabled them to invite the practice based health professions to a forum where any patient they are concerned about could be discussed and reviewed. This structure allowed the practice to get regular updates from other professionals i.e. consultants, learning disability teams, and community nurses.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Good

Are services effective?

- The practice offered annual health checks to patients with a learning disability.
- The practice provided rooms for mental health workers to provide services at both sites so that patients can be seen in safe and familiar surroundings, reducing the need for the patients to travel to the community sites. The practice worked with the voluntary sector for example the Alzheimer Society and provided rooms for them to see patients and their carers to help with managing dementia.
- The practices performance on quality indicators for mental health was consistently above average local and national averages.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- The practice overall score for QOF was 99.5%, this was above the CCG average of 93% and the national average of 96.5%.
- The overall exception rate was 4% this was lower than the CCG of 6% and the national average of 6%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.
- The practice regularly used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

Staff worked together in a cohesive manner and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

Good

Are services effective?

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- The practice was proactive and worked with local support agencies such as the Milton Keynes cancer patient partnership, helping hands, Alzheimer's society and age concern. Patients we spoke with told us that this continued support during and after treatments helped the emotional well-being with dealing with their experience.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity and cancer screening programmes.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.
- Written consent was obtained for all minor surgery and family planning.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The practice demonstrated a strong patient centre and community culture and we were given examples where the practice had gone over and above expectation to support vulnerable patients. For example, following liaison with the local police the practice had opened its services on a Sunday, outside of normal hours, to treat victims of human trafficking. The practice had continued to work with other agencies where in case of need they provided additional services without extra funding.
- Feedback from patients was positive about the way staff treat people. We were given many examples where staff had provided extra care for patients, for example patients that had no family were visited daily by practice to ensure they were managing until they were re housed.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results were consistently higher than local and national averages for questions relating to kindness, respect and compassion. For example, the percentage of patients who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern was 94% this was above the CCG average of 83% and the national average of 86%. This had improved from 91% in the GP patient survey published January 2016 data.

The percentage of patients who stated that the last time they saw or spoke to a GP, the GP was good or very good at listening to them was 97% this was above the CCG average of 87% and the national average of 88.8%. This had improved from 91% in the GP patient survey published January 2016 data.

- All 32 comment cards we received were wholly positive about the care given by the practice and two had both positive and negative comments.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them. The practice had identified 339 patients, 2.9% of their population as carers including young carers. The practice was aware that these young people although not sole carers may need extra support as they lived with relatives that needed full time care. The practice team worked closely with a wider group in Milton Keynes carers association on the Investors in carers programme.
- The practices GP patient survey results although statically comparable were consistently above local and national averages for questions relating to involvement in decisions about care and treatment. For example, the percentage of patients who stated the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care was 89.4% this was above the CCG average of 79.3% and above the national average of 82%. This had increased from 85% in the GP patient survey published January 2016 data.
- The percentage of patients who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care was 90.6% this was above the CCG average of 86.4% and the national average of 85.4%. This had improved from 89% as reported in the in the GP patient survey published January 2016 data.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Good

Are services caring?

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all the population groups as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. The practice recognised there were poor transport links for their patients and set up and supported the voluntary driver service.
- The practice offered appointments with GPs, nurses and health care assistants on Saturday mornings. They offered on the day appointments as well as pre- booked appointments at this time.
- The practice was proactive in bringing other services closer to the patient's home, for example they set up and provided space and equipment for the physiotherapy service. This service was further enhanced as patients were able to directly book in to see a physiotherapist who had extended skills saving the patients having to see a GP first for a referral.
- The practice provided an in-house micro-suction service and ENT consultations with one of the GPs who had additional training in this area. This service was offered to patients with more complex aural care needs to receive a safer treatment than usual ear irrigation without the need to travel to the local hospital.
- The practice served a population with a higher number of elderly people, and therefore the nurses undertook additional training to be able to provide a complex wound care service. This enabled those patients to be seen in the practice instead of travelling to the community clinics.
- The practice recognised that many patients who required social footcare did not meet the NHS criteria, therefore they hosted a private podiatrist on Wednesday afternoons at the Asplands site and on Monday afternoons at the Woburn site enabling those patients who wished to pay for this care to access it closer to home and in familiar surroundings.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The facilities and premises were appropriate for the services delivered. The practice had a proactive approach to maintaining these and worked with the PPG to ensure their signage was appropriate for people with conditions such as dementia and that there was braille signage for those who had a visual impairment. The practice was working with a local charity to support Woburn Sands in becoming a dementia friendly town.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice provided dispensary services for people who needed additional support with their medicines, for example a delivery service, weekly or monthly blister packs, large print labels.

Older people:

- The practice operated personal lists and all patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice had recognised the needs of their older patients and had set up additional services enabling older people to be seen closer to home. For example, staff were trained and equipment provided for them to manage complex wound care. Direct booking for timely physiotherapy assessment and those that did not meet the NHS criteria for podiatry were given the opportunity to obtain social care from a private provider.
- The practice undertook specialist tests (D-Dimer, and cardiac troponin monitoring. One of these tests is used to help rule out the presence of a blood clot). They told us this had contributed to their low A+E attendance, which were the lowest for the CCG area.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients. The practice recognised that the public

transport system was not easy for patients to manage. They had set up and continued to support a voluntary transport service for patients. Flexibility in arranging and managing appointment times was given to by the practice.
- The practice had been instrumental in setting up a lunch club for the elderly which is now run locally by a charity.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held weekly meetings with the local district nursing team and other allied health professionals to discuss and manage the needs of patients with complex medical issues.
- The practice was aware that patients who worked may find it difficult to attend appointments at the practice and therefore the practice nurses offered telephone consultations to monitor and support patient's health needs. This enabled patients to access this advice at times that were convenient to them.
- For those patients with diabetes, the practice nurses had received additional training to start to monitor patients who were using injections to manage their diabetes. This was more convenient for patients as they usually required several appointments within a short time frame.
- The practice worked with the local community diabetic nurses and had set up and hosted a diabetic workshop for patients at the practice to attend and discuss their conditions with a dietician, an in house diabetic nurse and a community diabetic nurse.
- Equipment including a 24 hour ambulatory blood pressure monitoring machine was provided by the practice and was easily accessed and allowed patients to monitor their blood pressure and weight were easily. The information was added to the patient's clinical records and routine follow ups could be brought forward if required.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this and we reviewed a case where this had been instrumental in protecting a patient where there were safeguarding concerns.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice provided a combined childhood immunisation service and baby clinic with the health visitor team on a weekly basis. A GP was available for the nursing or health visitor team to discuss any concerns without the patient needing to book a further appointment.
- The practice recognised that younger people often perceived barriers to accessing appointments, and they were concerned that younger people may not always seek advice, for example, for sexual health support, eating disorders and low mood. To overcome these barriers, they gave all young people aged 16 years old a card to have easy access for appointments on the day or as immediate as the person felt they needed.
- The practice participated in health promotion programmes aimed at reducing sexual health risks including contraception and safe sex advice and screening for cancer and sexually transmitted diseases including Chlamydia. The practice provided a full contraceptive service contraception including long acting device fitting and removal. A designated sexual health clinic was run weekly.
- Every summer the practice provided on-call medical services to a local large musical festival for young people. This ensured that young people who were staying away from home had easy access to healthcare should they need it.

Working age people (including those recently retired and students)

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, Saturday appointments are available for GPs and nurses and health care assistants.

Good

Are services responsive to people's needs?

- Equipment to allow patients to monitor their blood pressure and weight were easily available in the practice for patients to use. The information was added to the patient's clinical records and routine follow ups could be brought forward if required.
- The practice provided routine services such as NHS checks, cervical screening, smoking cessation and travel advice on Saturday morning giving these patients easy and timely access and promoting healthier lives.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. They were proactive in undertaking opportunistic health checks and screening whenever possible.
- Patients were given pictorial and easy to read information for example for patients with a learning disability cervical screening and contraception material that was easy to understand had been used.
- The practice clinical team had provided additional and intense support to a patient with a learning disability to manage their long-term condition effective and safely.
- The practice had clear systems to identify patients who may be receiving treatment that effected their immunity and well-being. The reception staff ensured they received timely care and were kept safe for example by minimising their waits in the waiting areas.
- The practice had worked with the police and other agencies to facilitate care of vulnerable people, this included special opening times of the practice.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. The practice allowed patients to use the practice address for receiving of mail and notifications. Practice staff contacted these patients to inform them if they had received any mail or notification such as hospital appointments.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients who failed to attend were proactively followed up by a phone call from a GP.
- The practice hosted a drug and alcohol worker, wellbeing workers, a counsellor and an Alzheimer's worker as they recognised that patients prefer local settings and that there are poor transport links locally to usual community clinics.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised. The practice had additional information easily available to identify patients who may have treatment such as chemotherapy to ensure they were given timely care and kept safe by appropriate waiting areas.
- Patients reported that the appointment system was easy to use. The practice regularly reviewed patient and staff feedback and made changes. For example, the practice recognised that sometimes there were potential delays to seeing the same GP and implemented a system to protect some appointments those patients who required review in one or two days.
- The practices GP patient survey results although statically comparable were consistently higher the CCG and national averages for questions relating to access to care and treatment. For example, the percentage of patients who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment was 83.9% this was above the CCG average of 77% and the national average 75.5%. This is the same percentage in the GP patient survey published January 2016 data.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.

Good

Are services responsive to people's needs?

- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.
- The practice acted on all feedback, for example some comments from the Family and Friends test related to patients complaining about the attitude of some reception staff. The management discussed with the team and an action plan was put in place. Actions taken included further training such as conflict resolution and care navigation.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development and succession planning, which aimed to ensure that the leadership represented the diversity of the workforce.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff reported they had full confidence in the leadership and management of the practice and were involved in decision making about the direction of the practice.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice ethos was 'Modern medicine with a traditional core'. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were involved in, aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a strong culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process. This was supported by the fact there was a low staff turnover. Staff reported that they felt the practice was a family.
- The practice demonstrated they focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed and could give examples of where they had done this. Feedback from these concerns was given at meetings. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. For example, a health care assistant had been supported to gain a foundation course in health qualification and to go on to undertake their nurse training and practice nurses to undertake services such as insulin initiation and complex wound care. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff. Several staff members shared their experience where the management had been supportive to them during difficult times.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

Good

Are services well-led?

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Clinical and administrative team attend weekly clinical governance meetings with set agendas to ensure they continue to improve and share learning.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective and processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through review of their consultations, prescribing and referral decisions. Practice leaders had oversight of safety alerts, incidents, and complaints. There was a demonstrated commitment to best practice performance and risk management systems and processes. The practice reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. Many of the audits looked at were multiple cycle audits.
- The practice routinely worked with the CCG and were had achieved high performance in the prescribing incentive scheme and in the low attendance figures at A+E. The practice told us these were reflective of the good access to clinical staff at the practice.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- There were consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.
- There was an active patient participation group (PPG). The group met quarterly with the practice and assisted with flu clinics. The practice implemented ideas from the group, including engagement with the various local charities and networks, discussion about new housing and primary care provision in the future.
- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the practice PPG provided a regular newsletter promoting healthcare and changes in the practice.

Good

Are services well-led?

- There was an active patient participation group. The group met quarterly with the practice and assisted with flu clinics. The practice implemented ideas from the group, including engagement with the various local charities and networks, discussion about new housing and primary care provision in the future.
- The practice proactively worked with groups such as the Milton Keynes Cancer and beyond to ensure the patients could benefit from the support available.
- The service was transparent, collaborative and open with stakeholders about performance. Feedback from external stakeholders was positive about the practice performance and engagement. The service took a leadership role in its health system to identify and proactively address challenges and meet the needs of the population. They regularly involved themselves in the community at local events, by giving health talks to build an effective and open rapport with patients.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There is a focus on continuous learning and improvement at all levels within the practice. For example, the practice was proactive in training medical students and GP registrars equipping them with the skills for future employment. The practice was looking at the provision of training for practice nurses, currently they support training placements for community nurses.
- Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care.
- Staff knew about improvement methods and had the skills to use them.
- One of the Partners is Chair of the Locality where seven practices have instrumental in setting up collaborative working. They have successfully employed two frailty nurses to work in the community to support GPs in managing patients who are at risk of falls. The group are looking at future projects including developing a primary care home
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared widely including to the CCG and other practices and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.