Dr Cassidy and Partners

Quality Report

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Date of inspection visit: 10 February 2015
Date of publication: 04/06/2015

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

Ratings

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

Summary of findings

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Overall summary

We carried out an announced comprehensive inspection at Dr Cassidy and Partners on 10 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be safe, effective, caring, responsive to people's needs and well-led. It was rated as good for providing services for older people, people with long-term conditions, families, children and younger people. It was also good at providing services for working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- There were good links with other health providers in the area and there was evidence of multi-disciplinary working
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it difficult to make an appointment, particularly when using the telephone system.
- 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.
- There was a clear leadership structure and staff felt supported by management.

Summary of findings

- The practice proactively sought feedback from staff and patients, particularly the active patient participation group, and it acted on this feedback.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should

- Actively monitor the impact of the newly implemented telephone system and the recently realigned appointment system to determine their effectiveness in meeting patients' concerns about access to the practice.
- Set out a clear, long-term strategy for the practice with objectives against which progress and improvements can be measured and ensure this is shared with staff.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is safe and is rated as good.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. The practice was clean and the risk of people acquiring a healthcare associated infection were minimised by the use of good infection control processes. There were enough staff to keep patients safe and equipment was safe to use. Staff could deal with medical emergencies and the practice had arrangements in place to ensure it could continue in the event of a major incident.

Are services effective?

Good

The practice is effective and is rated as good.

Data showed patient outcomes were similar to expected for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current guidance and standards. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multi-disciplinary teams and coordinated patients' care with other organisations. The practice effectively promoted good health.

Are services caring?

Good

The practice is caring and is rated as good.

Data showed that patients rated the practice similar to others for several aspects of care although there were some inconsistencies between observations and experiences of patients reported during the inspection and satisfaction ratings in the national patient survey. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained confidentiality. Patients received support to help them cope emotionally with their care and treatment.

Summary of findings

Are services responsive to people's needs?

Good

The practice is responsive to people's needs and is rated as good.

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. Appointments could be booked online, in person or on the telephone. Telephone consultations were available as well as extended opening hours each weekday evening and urgent appointments were available the same day. Patients said they found it difficult to make an appointment when using the practice's telephone system. The practice had responded to these concerns by deploying more staff at peak times, adjusting the times at which appointments became available and implemented a new telephone system with extra lines. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is well-led and is rated as good.

The practice had a philosophy of care shared by all staff that put patients first. The practice also had an open, transparent leadership style and learning culture. There was no documented vision, strategy or long term business plan but the practice was good at reacting to feedback from patients, from the patient participation group (PPG) and from staff to make improvements. Staff were clear about their role in putting patients first. There were clear governance arrangements and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular, structured meetings. There were systems in place to monitor and improve quality and identify risk. The PPG was active and regularly engaged with the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff were multi-skilled in chronic disease management. Patients at risk of hospital admission were identified as a priority and had proactive care plans. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary package of care. The practice provided physiotherapy and soft tissue injections for patients with long-term musculo-skeletal conditions. The practice carried out a process known as insulin initiation for newly diagnosed diabetic patients and near-patient testing for patients with suspected thrombosis.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The patient population served by the practice had a higher than average proportion of young families and children as compared with other practices in England. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk such as children subject of a child protection plan or looked after by the local authority. Immunisation rates were generally higher for this practice than for other practices nearby. Children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked effectively with midwives, health visitors and school nurses. There was a full range of family planning services available, cervical screening, opportunistic chlamydia testing and signposting to other sexual health services.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice had extended hours every week-day evening and had online services for prescriptions and appointment booking. The practice offered a full range of health promotion and screening that reflects the needs for this age group and carried out NHS health checks on patients aged between 40 and 75.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. The practice carried out annual health checks for people with a learning disability and for those living with dementia. Longer appointments for people with a learning disability or for those with complex needs.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 92% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice provided advice to patients experiencing poor mental health about how to access various support groups and voluntary organisations such as MIND and the Depression Alliance. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

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e spoke with nine patients on the day of our inspection. With one exception, everyone we spoke with reported that they were treated with kindness, respect and dignity by all the staff at the practice. Everyone said they were provided with plenty of information about their care and treatment.

A significant proportion of patients reported that they often had difficulty getting an appointment, particularly when using the telephone system, whilst others said they had no difficulty. All patients we spoke with said they could get to see a doctor the same day in an emergency whilst one patient said they would use the local walk-in centre.

We collected 44 comment cards that had been left for us by patients in advance of our visit. Mainly positive experiences of patients were reported on the comment cards with only two of the cards indicating any negative or critical views. Once again, the issue of access over the telephone was reported as being problematic.

We reviewed data from the most recent national patient survey. We noted that 62% of patients stated they would recommend the practice. This was among the worst rates nationally. The survey showed that 72% stated that they felt the practice was good or very good; this was similar to expected nationally.

Generally the survey indicated a variable experience of patients with satisfaction rates similar to the national average for some aspects of the practice and lower for others, particularly in relation to availability of appointments. Patient satisfaction rates for this practice showed that only 38% of respondents found it easy to get through by telephone, 48% described their experience of making an appointment as 'good' and 68% reported being able to successfully obtain an appointment the last time they tried and these were significantly lower than the CCG average.

The National Patient Survey showed that, on average, 71% of patients felt the GP was good giving them enough time, good at listening to them and good at explaining test results to them, whilst this figure rose to 90% in respect of the nurses at the practice. 66% of patients felt that the GP was good at involving them in decisions about their care, a satisfaction rate that was among the lowest 25% of such ratings in England. The corresponding figures for the nursing staff however, were similar to the average at 85%.

Areas for improvement

Action the service SHOULD take to improve

Actively monitor the impact of the newly implemented telephone system and the recently realigned appointment system to determine their effectiveness in meeting patients' concerns about access to the practice.

Set out a clear, long-term strategy for the practice with objectives against which progress and improvements can be measured and share this with staff.

Dr Cassidy and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Lead Inspector, supported by a GP specialist adviser and a Practice Manager specialist adviser.

Background to Dr Cassidy and Partners

Dr Cassidy and Partners, also known as Ashfield Medical Centre is a community general practice that provides primary medical care for just under 12,500 patients who live in the Beanhill, Netherfield and Coffee Hall areas of Milton Keynes. According to Public Health England, the patient population has a slightly higher than average percentage of patients aged between birth and 14 years and also between 25 and 40 years as compared with the rest of England. There is a less than average percentage of patients older than this with a significantly less than average for patients over 65. The practice is in an area considered to be in the lower 30% of economically and socially deprived areas in England.

Dr Cassidy and Partners has six GPs, four of whom are partners in the practice. There are three practice nurses, a senior nurse practitioner and two healthcare assistants who run a variety of clinics and screening sessions as well as members of the community midwife and health visiting team who operate regular clinics from the practice location.

There is also a practice manager and a team of non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8am and 7pm, Monday to Friday. Outside of these hours, primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider was 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.

This provider had not been inspected before and that was why we included them in this round of inspections in the Milton Keynes Clinical Commissioning Group (CCG) area.

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

How we carried out this inspection

We conduct our inspections of primary medical services, such as Dr Cassidy and Partners, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

Detailed findings

We carried out an announced visit on 10 February 2015. During our visit we spoke with two of the GPs, the practice manager, members of the nursing team and administration staff.

We spoke with nine patients using the service on the day of our visit and, subsequently to the chair of the patient participation group (PPG). PPGs are groups of patients that contribute views, activity and experiences to improve the quality of service. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed 44 CQC comment cards completed by patients using the service prior to the day of our visit day where they shared their views and experiences.

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

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

We also look at how well services are provided for specific groups of people and what care is expected for them. Those population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

We found that the practice used a range of information to identify risks and improve patient safety. For example, national patient safety alerts, medicines alerts and any complaints and concerns where patient safety was an issue, were raised at weekly practice meetings.

We saw that any adverse incident or event was recorded, analysed and discussed to ensure the practice learned and improved; a process known as significant event analysis (SEA). Significant events were discussed at meetings which were convened specifically for the purpose of reviewing such incidents. The most recent meeting had been held in January 2015 a month prior to our inspection. The staff we spoke with were aware of their responsibilities to raise concerns, events and near misses. The practice was consistent in its approach to SEA over time and had been recording the events and their outcomes in a separate file since July 2013.

Learning and improvement from safety incidents

The practice's system for reporting, recording and monitoring significant events, incidents and accidents was clear and robust and staff knew how to use the system effectively. This was by means of templated forms that the staff could use to report and escalate concerns with the most recent event being reported some five days before our inspection. Staff told us they were confident they could raise such events or any other concerns they had and that such concerns would be investigated thoroughly.

The separate significant event file was accessible to staff and it contained a record of all SEA over the previous 18 months. We reviewed these during our inspection and saw that a detailed analysis of events took place that resulted in learning points for either individual staff members or for the practice as a whole.

We looked at the notes of the last two significant event meetings that took place in August 2014 and January 2015. We noted that nine separate events were discussed between four of the partners and the practice manager over these two meetings. There were a variety of incidents discussed such as an administrative error, a prescribing concern, a vaccines management matter and an issue concerning the treatment of a person on a particular care pathway. Learning points were raised from each of these and communicated to relevant staff members. In some cases a process or operating system was adjusted as a result of the SEA. For example, one incident led to the procedure for recording additional details on referral forms being modified to ensure more accurate information was relayed at the point of referral to hospital.

The practice also accepted responsibility for the safety of patients arising out of such events. We saw that, where appropriate, patients were given an apology where they had been affected by an incident; for example, in one case where there had been a prescribing error.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were monthly 'palliative care and safeguarding' meetings with the health visiting service and the community nursing team. We reviewed the records of the last four of these meetings and saw that the needs of patients who were receiving end-of-life care were discussed as well as the needs of patients about whom there were concerns. This included vulnerable adults and children who were looked after by the local authority or subject of a child protection plan.

The practice had a named lead GP for safeguarding vulnerable adults and another named GP for child protection. Both had been trained to a more advanced level and had responsibility for liaising with the local safeguarding boards in individual cases. Other staff knew who the lead staff members were and told us they would report concerns direct to them or to the practice manager or another member of senior staff in their absence. Staff had received appropriate training in safeguarding and told us they would be able to recognise and respond to signs of potential abuse. During our discussions with staff it was evident that their level of knowledge and understanding of abuse and of the local procedures was appropriate for their role.

There was a chaperone policy in place. A chaperone is a person who is present during an intimate or sensitive examination in order to safeguard the rights of the patient and the clinician during such an examination. All staff, including health care assistants and reception staff, had been trained to carry out this role. In addition, all reception

Good

Are services safe?

staff had been subject of a criminal records check with the Disclosure and Barring Service (DBS) and this helped the practice to minimise any risk to patients from the chaperone procedure.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including scanned copies of communications from hospitals or other services. Access to this system was through a smartcard and a unique password. The practice used minimal paper patient records. Where paper records were used these were filed away securely after use in accordance with a clear desk policy which required all staff to lock away paper documents with confidential personal information.

Medicines management

We found that there were clear procedures for the management of medicines that minimised the potential for error. For example, we found evidence that the nursing team were working with patient group directions (PGDs) that were up-to-date, signed and held on the practice intranet. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before they present for treatment, such as vaccinations or family planning medicines.

We saw that the cold chain was maintained for the storage of temperature sensitive medicines, such as the flu vaccine, from the time they were received at the practice to the time they were administered. There was a system for monitoring the fridge temperatures daily so that the practice was assured the vaccines remained viable and safe to use. We noted that the temperatures were recorded as consistently being between the acceptable upper and lower limits.

Processes were in place to check that medicines, including those for use in an emergency, were within their expiry date and suitable for use and these checks took pace weekly. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of appropriately.

There was a safe system in place for managing repeat prescriptions. Prescriptions could be ordered by hand, through the local pharmacy or by using the practice's online system and we saw that there was a safe system in place for receiving, checking, authorising and re-issuing prescriptions. Patients who were housebound, frail or disabled could order repeat prescriptions over the telephone between certain times.

The practice did not stock controlled drugs.

Cleanliness and infection control

We found the practice to be clean and tidy on the day of our inspection. Cleaning schedules were in place and records were kept that helped the practice to monitor the effectiveness of the cleaning process. Clinical waste and used sharp instruments were disposed of in appropriate bins and containers in accordance with Department of Health guidance. Patients we spoke with told us they always found the practice to be clean and had no concerns about the risks of infection.

A member of the nursing staff was designated as the lead for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received regular updates during scheduled practice learning periods which the practice called 'protected time'. For example, we saw that a presentation on different types of infection, cleaning processes, hand washing and general preventative practice was carried out at a protected time session in September 2014.

We saw evidence that the practice had carried out a regular infection control inspection, the last one being in July 2014. We saw that actions had been identified during these reviews and changes had been made as a result.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to undertake measures in their everyday work to help control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy and we saw that these were in use during our inspection. There was also a policy for needle-stick injury and staff knew how to respond in the event of such an injury occurring.

Notices about hand hygiene techniques were displayed in staff and patient toilets and in consultation and treatment rooms. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Good

Are services safe?

The practice had carried out a risk assessment on the management, testing and investigation of legionella, a germ found in the environment which can contaminate water systems in buildings.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was well equipped with adequate stocks of equipment and single-use items required for a variety of clinics, such as the asthma clinic, and procedures, such as minor surgery.

Staff told us that all equipment was tested annually and maintained regularly and we saw records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that relevant equipment such as blood pressure monitors, a spirometer and an electro-cardio gram (ECG) machine were regularly calibrated to ensure they were operating safely and effectively.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to people being employed. For example in the four staff records we reviewed we saw proof of identification, references, qualifications, registration with the appropriate clinical professional body, criminal records checks through the DBS and an appropriate interview check-list. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff; for example, a requirement for DBS checks to be undertaken for all staff, clinical and non-clinical.

We saw that the practice planned its staffing requirement around the services it provided so that there were enough competent staff on duty with the appropriate skill mix at all times to support safe care and treatment. We looked at staff rotas and saw that they were set in advance. The staffing requirement was managed through the weekly practice meetings. In this way, planned absences such as staff leave and unexpected absence due to sickness were managed and cover arranged as appropriate. Non-clinical staff had been trained in a variety of roles so that they could cover in each other's absence.

Monitoring Safety & Responding to Risk

We saw that the practice had procedures in place to deal with potential medical emergencies. All staff had received training in basic life support and received update training annually. This included training on responding to patients suffering anaphylactic shock associated with an allergic reaction to vaccines as well as chest pain and patients who might collapse or otherwise be in distress. Staff we spoke with confirmed they were confident they could respond to an emergency effectively in a variety of scenarios.

Reception staff also told us they were confident that they could identify patients who were very unwell and who might need to be seen by a clinician as a priority, including by reference to alerts shown on the computer screen for patients with particular risks. They provided examples of occasions when patients' consultations had been expedited as a result.

Staff had access to an automated external defibrillator (AED), a device used to restart the heart in a medical emergency, as well as emergency oxygen. The practice carried a stock of medicines for use in the event of a medical emergency. These included medicines for use for people experiencing chest pain, a diabetic emergency, anaphylactic shock or respiratory problems. The emergency medicines were checked weekly to ensure they were within their expiry dates.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The plan, which was last updated in August 2014, included relevant contact information for local services and commissioners to enable rapid contact to be made with relevant organisations. The document was kept under review and hard copies were located both on and off-site.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and medical staff changes were managed through a process that the practice described as a triangular system of responsibility. This process relied upon two groups of three GPs arranged in a three-way buddy system that enabled cover to be provided on a rotational arrangement within each group in the event of unexpected absence.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. The practice had identified a lead clinician for each specialist clinical area, such as diabetes, chronic lung conditions and people approaching the end of their lives. They were responsible for providing clinical direction to the practice's approach to these conditions.

We saw that the practice had arrangements in place to ensure all staff were aware of and adhered to expected standards of care. Two of the practice partners attended monthly meetings of local GPs, one of four 'neighbourhoods' of the Clinical Commissioning Group (CCG). New information or guidance arising from these meetings, together with evolving quality standards from the National Institute for Health and Care Excellence (NICE) and medical journals were discussed and assimilated during weekly practice meetings. Any relevant information was also cascaded to other staff during monthly protected time sessions. For example, we saw that information about applying the criteria for flu vaccinations was communicated to staff during the protected time meeting of November 2014.

As a result, the practice's management plans and protocols for particular conditions or treatments were reviewed, updated and put into practice. For example, patients with long term conditions were noted on a long term conditions register and we saw that guidance and protocols were followed to ensure their care and treatment was regularly reviewed in line with the NICE guidance. We also noted that the practice carried out a process known as 'insulin initiation'. This is a longitudinal process that supports patients recently diagnosed with type II diabetes with the implementation of their treatment plan over time where their condition is controlled by insulin.

We saw that every patient receiving end-of-life care was reviewed each month at a multi-disciplinary team meeting involving the community nurses to ensure that their specific and evolving needs were met. The practice used a risk tool to identify patients that were most at risk of repeated admissions to hospital through attendances at accident and emergency. Those patients were allocated longer, 30 minute appointments. A comprehensive assessment of their needs gave rise to a personalised care plan.

The practice's patient population was diverse. During our inspection we saw no evidence of any discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

We saw that the weekly practice meetings and the practice's protected time sessions played a key role in monitoring and improving outcomes for patients. For instance, the practice actively ran regular searches using their computer system and the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality. The QOF is the national data management tool generated from patients' records that provides performance information about primary medical services.

The outcomes of these searches, and any other data that indicated the way the practice was performing, were discussed at the practice meetings and cascaded to staff during protected times where necessary. For example, in November 2014 the data from the QOF had indicated that the practice was falling short in the number of flu vaccinations for particular groups of patients. Our own examination of the QOF and other nationally available data showed that the practice was performing as expected across a range of attributes in comparison with the rest of the CCG area and England with the exception of the take-up of flu vaccines and the use of a group of medicines known as hypnotics.

The practice had addressed the shortfall in the flu vaccine take-up by discussions within the clinical team and with the practice staff. They had explored ways that they could ensure that patients who were in particular target groups could be proactively identified and offered the vaccine, such as those patients who might be housebound or those living in care homes.

We saw that the practice had also taken steps to understand why the data about flu vaccines was indicating a low take-up rate. The lead GP had engaged in discussion with NHS England about how information about the flu vaccines was recorded on the practice system and the way

Good

Are services effective?

(for example, treatment is effective)

the data was gathered. As a result the practice were planning to undergo a process of data cleansing at the time of our inspection to ensure they could gain a clearer picture of their performance in this area.

In response to the national data showing elevated levels of prescribing of hypnotics, the practice had carried out a review of patients who were prescribed benzodiazepines, one of the types of medicines in this group. We saw that this had resulted in modified treatment plans for those patients aimed at ensuring a long term reduction in the use of these medicines.

As well as QOF information, the clinical meetings considered significant events, complaints, medicine alerts and audits in order to inform the way the service was run. Our examination of a sample of the records of the clinical meetings for the year prior to our inspection showed numerous examples where this information had been discussed and acted upon.

The practice carried out a range of clinical audits to assess their performance in particular areas. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented in order to assess their effectiveness. We looked at the records of a sample of three audits that had been undertaken in the last two years. These were a joint and soft tissue injection audit, a diabetes non-attendance audit and an opiate prescribing audit. We noted that the practice had implemented changes as a result of the initial audits and that the impact of the change had been measured in a subsequent audit. For example, diabetic patients who had historic, repeated instances of non-attendance for follow-up appointments were provided with additional written information about their medication and their condition. They were engaged in further discussions about their diet and lifestyle in order to enhance their understanding and self-management of their condition. This had resulted in measurable improvements in their blood sugar levels over a six month period.

We saw that the practice had engaged in local benchmarking exercises with the CCG. For example, in December 2014 the practice had carried out a review of their prescribing behaviour under a prescribing incentive scheme. These were for the prescribing of opioid analgesics, steroids used in the treatment of chronic lung conditions and delayed antibiotics for use in respiratory tract infections. These reviews had resulted in actions plans that the practice was committed to implementing and re-auditing.

Effective staffing

Practice staffing included clinical (GPs and nurses) and non-clinical roles (managerial and administrative staff). We looked at records and spoke with staff and found that both clinical and non-clinical staff were appropriately trained and supported to carry out their roles effectively. For example, nursing staff had been trained in immunisations, asthma, cervical smears, diabetes and other long term conditions; healthcare assistants had received training in carrying out health checks and taking blood samples.

GPs had their own areas of expertise which enhanced the service they were able to provide to their patient population. For example, one GP had expertise in diabetes, another specialised in respiratory conditions and another in minor surgery.

New staff received a comprehensive induction programme that introduced them to their role. Non-clinical staff were trained to carry out more than one task. We noted that all administrative staff could carry out reception duties to enable the practice to remain effective during peak times. There was a system in place to ensure staff received training that was considered to be mandatory, such as basic life support training, health and safety and safeguarding. Some reception staff had also been trained to carry out the role of chaperone. All reception staff had been subject of a criminal records check with the Disclosure and Barring Service (DBS)

All clinical staff were appraised annually and undertook continuing professional development in order to fulfil the revalidation requirements of their professional bodies such as the General Medical Council and the Nursing and Midwifery Council. All newly appointed non-clinical staff received an annual appraisal. A programme to introduce annual appraisals for existing non-clinical staff was being implemented at the time of our inspection. Nonetheless, staff we spoke with said they felt supported. This was borne out by the comprehensive programme of training and monthly protected time sessions designed to ensure staff were kept updated.

The practice supported the training of foundation doctors (qualified doctors undergoing post-qualification training)

Good

Are services effective?

(for example, treatment is effective)

by offering opportunities to develop their skills in general medicine through attachments. We saw that the established partners promoted learning and supported foundation doctors through a clinical supervision programme. GPs at the practice also participated in discussions on NICE guidelines and scientific publications at meetings they referred to as a 'journal club' and this ensured their clinical knowledge was always up to date.

Working with colleagues and other services

We found that the practice engaged regularly and effectively with other health care providers in the area such as the district nursing team and the health visitors, the emergency department of the local hospital and the local ambulance service. We saw, for example, that a daily handover of information about patients using the district nursing service took place at 12.30pm, supported by a message book that was reviewed regularly during the day.

The practice had an in-house physiotherapist and a visiting midwife that provided pre-bookable appointments. Smoking cessation advisers also visited the practice.

All records of contact that patients had with other providers, including blood and other tests such as x-rays, were received electronically through an IT system link. Thereafter they were reviewed and followed up by a GP within 24 hours.

The evolving needs of every patient receiving end-of-life care, as well as children at risk and patients with complex needs were discussed at monthly multi-disciplinary team (MDT) meetings. The MDT meetings involved the GPs, nurses, practice manager, health visitors and the district nursing team. As patients neared the very end-of-life, their care plans and any documents that related to their decisions about resuscitation were sent to the ambulance service and the out-of-hours service to ensure that specific wishes about their death could be met.

We saw that three of the doctors provided occasional voluntary sessions for the Milton Keynes Urgent Care Service, a local 24-hour urgent treatment service accessible through the out-of-hours NHS 111 telephone number.

Information sharing

The practice used an established electronic patient records management system (known as SystmOne) to provide staff with sufficient information about patients. All staff were trained to use this system. The system carried personal care and health records and was set up to enable information to be communicated about particular patients, such as children known to be at risk.

The system also enabled correspondence from other health care providers, such as discharge letters or blood and other test results, to be transferred and held electronically to reduce the need for paper held records. The practice system was also the gateway to the 'choose and book' system which facilitated the management of referrals on to other services such as the hospital outpatients department. This system was readily available and accessible to all staff.

The practice had begun to use the electronic Summary Care Record system. The summary care records provide key, clinical information about individual patients to healthcare professionals to enable faster access in an emergency or out of normal hours. For patients who were referred directly to hospital by the practice, a printed copy of their summary record was provided for them to take with them to hospital.

Consent to care and treatment

We found that patients' consent to care and treatment was always sought in line with legislation and guidance. This consent was either implied, in respect of most consultations and assessments or was explicitly documented, in the case of, for example, minor surgical procedures. For such procedures the practice used template forms, otherwise patients' consent was recorded in their electronic records. For example, we saw that the practice's joint and soft tissue injection audit noted that consent was recorded in 79 out of 80 procedures indicating that the practice's approach to consent was consistent.

Patients we spoke with on the day of our visit told us that they were always provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

We also saw that the practice applied well-established criteria used to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone with parental responsibility. We saw that the provisions of the Mental Capacity Act 2005 (MCA) were used appropriately and that assessments of patients thought to

Good

Are services effective?

(for example, treatment is effective)

have limited capacity to consent were carried out diligently and with the involvement of key people known to those patients. This was particularly relevant for patients who had a learning disability or patients who lived with dementia.

Health promotion and prevention

There was a range of up-to-date health promotion literature available in the waiting area with information about physical and mental health and lifestyle choices. For example, we saw that there was information available on diet, smoking cessation, alcohol consumption, contraception, sexual health, ageing, cancer and carer support among many others.

We saw that all new patients were asked to complete a general health questionnaire when they first registered and were invited into the surgery to see a nurse or healthcare assistant for a health check and exploration of their medical history and lifestyle. All patients over 40, including those also over 75, were invited to receive a NHS health check by healthcare assistants that had been trained to carry this out.

The practice also provided flu vaccinations to those who were most at risk although there were some inconsistencies in the way that information about take-up of the vaccination was recorded that the practice were addressing. Screening for chlamydia (a sexually transmitted infection common among young people) was also provided by the practice according to current guidelines.

The practice provided a full range of childhood immunisations and nationally collected data showed that they were reaching generally similar or slightly higher rates in comparison with the rest of the CCG area. The same national data showed that the practice achieved expected take-up rates for cervical screening. The data also showed that the practice was performing as expected for its treatment of patients with preventative anti-coagulation medicines, as well as for those patients living with dementia or with a learning disability who had received a face-to-face review of their health needs.

The practice ran health promotion clinics for long term conditions such as diabetes, asthma and heart disease and these were advertised on the practice web-site. Clinics were also held for smoking cessation, blood pressure monitoring and weight management. The practice also provided a full range of family planning services including the fitting of intra-uterine devices.

Patients who required extra support were identified and care was tailored to meet their needs. For example, three of the patients we spoke with on the day of our inspection whom had particular long-term health needs told us that the practice had managed their care well and had explored ways of minimising the effects of their illness. Furthermore, we saw that patients who were receiving palliative care were discussed at monthly MDT meetings where the effectiveness of their individualised care plans was considered. The practice had a carer's register which ensured that people who were looking after others were identified, offered the opportunity for additional support and referred onwards to other services.

We noted that nationally collected data on patient outcomes showed that the practice had a higher than expected number of patients with particular conditions who had attended the hospital emergency department. The practice had identified those patients who were most at risk of attending hospital in these circumstances and had ensured that they were offered 30 minutes appointments where necessary in order to reduce this risk.

As reported above, the practice also supported the local health economy by providing three of the GPs on an occasional, voluntary basis to run sessions in the local urgent care centre.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with nine patients on the day of our inspection and reviewed 44 comment cards that had been collected from patients in advance of our visit. We also looked at data from the 2014 National Patient Survey, considered reviews posted on NHS Choices (13 reviews in the two years prior to our inspection) and carried out observations throughout our inspection.

The data from the 2014 National Patient Survey showed variable findings. We noted that 72% of patients stated that they felt their overall experience of the practice was good or very good and this rating was similar to expected. However, only 62% of patients stated they would recommend the practice and this was among the worst ratings nationally.

The experience of patients reported to us during our inspection was generally positive. For instance, with one exception, patients we spoke with told us that they were treated with kindness, respect and dignity by all staff. Patients reported that their GP and the nurses were courteous, considerate and compassionate and that the practice was friendly and welcoming, although one patient told us they felt that one GP treated them in a condescending manner. All but two of the comment cards we collected contained positive comments about the manner of the staff and the way patients were treated. The two other cards reported several negative experiences including complaints of being treated with a lack of concern and no patience.

However, the generally positive comments did not completely reflect the responses of patients in the National Patient Survey, which were inconsistent. The survey showed a 66% satisfaction rate among patients who thought they were treated with care and concern by their GP; among the lowest 25% of ratings nationally. Whereas the satisfaction rates for patients who felt they were treated with care and concern by nurses at the practice was at 84%, which was similar to expected.

Patients also told us that all the reception staff were polite and had a pleasant manner with patients. During our observations in the reception area we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the reception desk. We noted that staff were always polite and treated patients with respect and empathy. This was borne out by data from the 2014 National Patient Survey showing that 80% of patients reported the reception staff as being helpful; this satisfaction rating was similar to expected.

A notice at the reception desk asked patients to respect the privacy of patients already talking to reception staff. However, there was no line behind which patients could wait before being called forward. There was however, a separate interview room and staff told us that this was used to speak with patients who might wish to talk privately. There was also an isolation room that was used for patients who were unwell with conditions that might be infectious. Data from the 2014 National Patient Survey showed that patients at this practice felt they could not be overheard in the reception area.

We saw that there was a chaperone policy in operation and a notice was displayed in reception and in each consultation room that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Female patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a male doctor. All members of staff including reception staff could carry out the role of chaperone.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National Patient Survey showed that, on average, 71% of patients felt the GP was good giving them enough time, good at listening to them and good at explaining test results to them whilst this figure rose to 90% in respect of the nurses at the practice. 66% of patients felt that the GP was good at involving them in decisions about their care, a satisfaction rate that was among the lowest 25% of such ratings in England. The corresponding figures for the nursing staff however, were similar to the average at 85%.

This was a disparity that we were unable to explain since the views expressed by people on the day of our inspection about their involvement were all positive. All nine of the patients we spoke with on the day told us that both the nursing staff and the GPs gave them enough time and provided sufficient information to enable them to understand their care and treatment. Patients said they felt

Good

Are services caring?

in control, involved in their treatment planning and had the opportunity to ask plenty of questions if they were unsure. Similarly, none of the 44 comments cards we reviewed reported negative experiences of patients in relation to their involvement whilst several overtly stated that they felt involved.

We found that patients who were referred onwards to hospital or other services were involved in the process. Patients and staff we spoke with told us that referrals on the 'choose and book' system were made through the secretaries with patients being given a form to complete to return to the practice to indicate their choices.

The practice also had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment. However, this service was used very rarely as some of the staff could speak a range of languages such as Hindi, Punjabi, Guajarati, German, Russian and Zimbabwean.

Patient/carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, particularly those that were recently bereaved.

For example, staff we spoke with told us they were made aware of the names of the patients who had recently deceased by means of an alert on the computer screen. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support. In any event, all bereaved patients were called by a GP in order to ascertain their particular support needs.

Notices in the waiting area sign-posted patients to support from local services, such as organisations for patients with cancer and other conditions and for those who were bereaved. The practice provided particular support for bereaved parents and ensured timely access to specialist and support services for terminally ill children and their parents.

We saw that the practice had a particularly informative section on the web-site that provided information about a range of services that were available for patients who were caring for others. Carers were identified by the practice and were proactively signposted to a local carer's support organisation or referred directly to the service if necessary.

The emotional needs of patients receiving end-of-life care were considered during monthly multi-disciplinary team meetings as part of their individualised care plans.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. The practice made use of an alert system on the computerised patient database to help them to identify patients who might be vulnerable or have specific needs. This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care or those who were recently bereaved. The alert system also identified individual patient's risk to enable clinicians to consider issues for their consultations with patients, such as patients who were particularly frail or at risk of unplanned hospital admissions. A dedicated member of staff had particular responsibility for co-ordinating the care of patients who were at such risk or who had such complex needs.

The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and smoking cessation advice.

The practice served the needs of patients living in two local care homes where they carried out both routine and ad hoc visits as required. Older patients admitted to these homes who were receiving end-of-life care were registered at the practice as new patients and their care and treatment was planned as part of the practice's palliative care register.

Two of the practice partners attended monthly meetings of local GPs, one of four 'neighbourhoods' of the Clinical Commissioning Group (CCG). This enabled the practice to understand the needs of the local population and consider their role alongside other GPs in providing primary medical care in the locality. For example, we learned that the practice carried out a near-patient screening test for their, and a neighbouring practice's patients for patients in whom thrombosis was suspected.

The community nursing and health visiting teams were located in the practice and this enabled informal ad-hoc dialogue to take place about patients' needs. This was in addition to the monthly multi-disciplinary team meetings set up to discuss patients receiving end-of-life care and other patients at risk.

The practice had an active patient participation group (PPG), a group made up of patients' representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. We found that the practice had responded to ongoing concerns about access to the practice arising from feedback from the PPG, from survey reports and from national recorded data by implementing a number of improvement initiatives. This is reported in more detail under 'Access' below.

Tackling inequity and promoting equality

The practice had a diverse workforce and had recognised the needs of different groups in the planning of its services. For example, the practice offered a home visit phlebotomy service, co-ordinated by the community nursing team based at the practice, for patients with learning disabilities, those receiving end-of-life care and older or housebound patients.

The practice also had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment. As reported above, this service was used very rarely as some of the staff could speak a range of languages.

The practice had an up-to-date equality and diversity policy. This was supported by equality and diversity training that all staff at the practice had undertaken during one of its on-site protected time sessions.

Patients who were short-term visitors to the area, such as members of the travelling community, could access care where this was immediately necessary and by registering as a temporary resident. In such cases, patients were registered on the patient management system straight away so they could be allocated an appointment.

We also saw that the practice was configured in a way that enabled disabled patients, those in wheelchairs or parents with pushchairs to access their GP or the nurses. All consulting rooms were on the ground floor. There was level access throughout with widened doorways and an accessible toilet.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice opening times were 8am to 6.30pm, Monday to Friday with the practice closed at weekends. Consultations were available through appointments booked on-the-day or in advance and the practice also offered same-day telephone consultations. Children and frail older patients were prioritised to be seen on-the-day.

The practice was located in an area which has a higher than average proportion of working age people between the ages of 25 and 40 years and of younger patients aged between birth and 14 years. Data from Public Health England showed that the practice was located in an area considered to be in the lowest 30% socially and economically deprived. In our discussions with the GPs, practice staff and with a member of the PPG, we learned that the high proportion of younger families brought particular challenges around the timely availability of appointments. As a result, the appointment system had evolved so that traditionally, more appointments had been available for booking on-the-day than those available for booking in advance.

National Patient Survey data showed that 75% of patients were satisfied with the practice's opening times and that they generally waited less than 15 minutes after their allotted time before being seen by a clinician. These rates were similar to expected. However, the same data also indicated that access to appointments through the telephone system was problematic, despite patients having the ability to book through the practice's online facility since March 2014.

Patient satisfaction rates for this practice showed that only 38% of respondents found it easy to get through by telephone, 48% described their experience of making an appointment as 'good' and 68% reported being able to successfully obtain an appointment the last time they tried. The comparative satisfaction rates for the rest of the CCG area were much higher at 57%, 62% and 83% respectively.

Twelve of the 44 comment cards left for us by patients in advance of our inspection commented adversely on the availability of appointments, particularly through the telephone system, with reported delays of between 20 and 40 minutes before being answered. Four of the nine patients we spoke with on the day also said it was difficult to get through on the telephone. One patient said that they had often had to resort to coming down to the practice to stand in line when it opened to secure an appointment for that day whilst another said they often used the nearby walk-in centre instead. This was borne out by our observations on arrival at the practice on the morning of our inspection. We noted that 11 patients were waiting outside before the practice opened. Seven of these patients queued at the reception desk and left a short time later with a slip of paper indicating an appointment time for later in the day.

One of the priorities for the PPG in the year preceding our inspection had been the issue of access to the practice in terms of both the telephone system and the availability of appointments in general. This had been raised as a problem by the data collected from a patients' survey that the practice carried out in 2014 and had formed part of the PPG actions. The practice told us they had approached this issue with three separate initiatives. The practice had adjusted the availability of its appointments so that one-third were available for pre-booking up to six weeks in advance, one-third were available for booking the next day and the final third were available on-the-day. The practice had also recruited additional reception staff and had realigned working times to enable additional staff to be on duty at peak telephone times early in the morning. Finally, and of most significance, the practice had installed a new telephone system that enabled more calls to be handled simultaneously and that advised patients where they were on the system's queue so they could choose whether or not to hold on.

At the time of our inspection, these initiatives had just been implemented in response to the concerns about access and so we were not able to assess whether they had been effective. In any event we were assured by the practice that they were addressing the issues and that they would monitor the implementation of the initiatives on an ongoing basis.

Listening to and learning from concerns and complaints

The practice listened to concerns and responded to complaints to improve the quality of care. The practice had a system in place for handling complaints and concerns according to a policy that was in line with recognised guidance and contractual obligations for GPs in England. There was information on the practice web-site, in leaflet form in the reception area and in a notice on the notice board advising patients of the complaints procedure. The complaints leaflet correctly referred patients to other NHS

Good

Are services responsive to people's needs?

(for example, to feedback?)

bodies where this was required and also provided advice about independent advocacy. All of the patients we spoke with said they had never had cause to complain and told us they would know how to complain if necessary.

We noted that the practice took action to investigate complaints and discussed patients' concerns with the relevant staff member to whom the complaint referred. As with significant events, complaints and comments were discussed at the weekly practice meetings so that the practice could learn from patients' experiences.

We looked at two complaints received in the last three months and saw that these were satisfactorily handled and dealt with in a timely way in accordance with the practice policy. In both complaints the practice had taken appropriate action and had sent formal letters of apology to the complainants outlining their recourse to NHS England or the Ombudsman if they were dissatisfied with the outcome.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a shared philosophy of care that put patients' needs first. For example, we reviewed the practice's statement of purpose they sent to us as part of their submissions in advance of the inspection. In this document, the practice stated that the GPs acted as advocate for patients, supporting and representing their best interests to ensure they received the best and most appropriate health and social care. All the staff we spoke with said they understood that they were there for the benefit of patients. We also noted that the practice had held a protected time session in July 2014 when guest speakers had outlined the future direction of primary care services both nationally and in the area. This had enabled staff to gain a clear picture of the future of primary care and the practice's role in it.

Although there was open and transparent leadership and a shared understanding of good patient care, we found that there was no clear vision or strategy to develop the practice that was shared by all the staff. There was also no long term business plan that set out any goals for the practice against which its progress might be measured. The practice had generally made improvements to its services as a result of it being responsive to patient and staff feedback, such as the initiatives recently implemented to improve patient access. In this respect we saw that the practice was receptive and had a firm commitment to improving. However, the absence of a vision or strategy illustrated that its approach was very much reactive as opposed to proactive. As a result, there was limited opportunity to develop organisational learning or to tailor future services based on how well such a strategy might be working.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. The practice had identified a lead clinician for each specialist clinical area, such as diabetes, chronic lung conditions, vascular conditions and for people approaching the end of their lives. They were responsible for providing clinical direction to the practice's approach to these conditions. The senior partner was the clinical governance lead for the practice.

Medical staffing was governed by a triangular buddy system where two groups of three GPs rotated their different responsibilities, such as the duty doctor, and arranged cover for absences and leave where necessary.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity.

The practice also actively used feedback from complaints, concerns and the findings of significant event analyses (SEA), clinical audits and CCG benchmarking activity in order to understand and manage any risks to their service. We looked at a number of examples of each of these as previously set out earlier in this report. The practice also engaged regularly with its patient participation group (PPG) as reported below.

Decision making and communication across the workforce was structured around key, scheduled meetings. Practice governance meetings took place weekly, where QOF data, audits and clinical issues were discussed. SEAs, complaints and other learning opportunities were discussed at monthly meetings convened for that purpose. These were supported by the monthly palliative care and safeguarding meetings whilst the practice also participated in monthly CCG neighbourhood meetings. In this way the practice kept abreast of key issues internally and externally. The staff team were briefed about any changes as and when they occurred but in any event at monthly half-day protected time sessions at which they were all present.

There were clear policies for each aspect of the practice's business accessible to staff through the practice computer system and these were subject of periodic review to ensure they were up-to-date. Staff were made aware of key policies during induction and could get access to clear instructions or protocols that set out how their work was to be performed.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice's informal philosophy of putting patients first. The partners and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy and a culture of empowerment existed

Are services well-led?

Good

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

for all staff to raise issues whenever they wished and without blame. This egalitarian structure enabled any issues to be reported and discussed properly at practice and other meetings and with an emphasis on learning.

The practice manager explained that there was a low turnover of staff in all roles and that the workforce was stable. We noted that staff were positive in their attitudes and presented as a happy workforce. They told us they felt supported and valued. We considered this to be evidence of the effectiveness of the leadership approach adopted by the practice and this was a view shared by the chair of the PPG.

There were robust policies in place that had the practical effect of supporting staff. For example, we noted that there was a zero tolerance policy in place in relation to abuse or violence towards staff and this was overtly publicised in the practice and on the web-site. This demonstrated that staff safety and wellbeing was a priority for the practice treated.

Seeking and acting on feedback from patients, public and staff

We found that the practice engaged actively with its PPG. Such groups are made up of patients' representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. The practice manager was the designated lead role for the PPG at the practice which met every six to eight weeks, reporting their activity through the minutes of the meetings and an occasional newsletter posted on the practice web-site and in the waiting area.

The chair of the PPG told us that its membership had increased somewhat over the last year. This was due to the introduction of a policy whereby new patients were given a PPG registration form as part of the practice registration documents and were actively encouraged to join. We looked at the profile of the PPG and saw that it was generally representative of the patient population with both men and women of varying ages, although mainly in older age groups. The PPG had a regular membership of just over 40 and over 250 members of a 'virtual' PPG, patients who were contributed their views electronically without attending meetings.

It was evident from the notes of the PPG meetings that the group was both supportive and challenging when required and the engagement with the group had led to the adoption of a number of initiatives. For example, text reminders had been introduced to help offset the missed appointment failure rate and these had shown an improvement at the end of 2014. Further, we learned of two evening events that had been run in conjunction with the PPG designed to raise people's awareness of certain conditions. These events, one on diabetes and the other on men's and women's health, had been held at the practice on separate occasions during 2014. These had had enabled the practice to provide nursing staff to carry out some simple health checks such as blood pressure measuring for those that attended. We learned that a further event was planned for 2015 in conjunction with Age UK.

As well as the PPG, the practice actively sought feedback through an electronic feedback form on its web-site. They also collected data from the Friends and Family test through feedback forms in the waiting area which asked patients to comment on the practice's cleanliness, the helpfulness of reception staff, involvement in care and treatment and the ease of getting appointments. We saw that the January 2015 survey showed a rating of 4.5 stars out of five from 75 contributors.

There were no staff surveys carried out. However, we learned that staff were able to contribute ideas that were sometimes adopted as good practice. For example, a change in the call and recall system for patients with diabetes to ensure it covered all relevant patients had arisen from a suggestion form a nursing staff member.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system for nurses and all new staff, the recent introduction of appraisals for existing staff and opportunities for learning through protected time sessions.

The practice also had an open learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working.

Are services well-led?

Good

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

The practice was registered with Oxford University and the Oxford Deanery as a GP training practice. The practice regularly deployed foundation doctors (qualified doctors undergoing post-qualification training) by offering opportunities to develop their skills in general medicine through attachments. We saw that the established partners promoted learning and supported foundation doctors through a clinical supervision programme.