

The Red House Surgery

Quality Report

241 Queensway,
Bletchley,
Milton Keynes,
MK2 2EH
Tel: 01908 375111
Website: www.redhousesurgery.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Red House Surgery on 8 June 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice was working collaboratively with another local practice to promote the Living in the Moment Group, which ran from a local community hall. The group offered support and advice to people who found themselves feeling isolated or lonely.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice was involved in supporting patients recovering from cancer treatment once they were discharged from hospital care through a group called 'Cancer and Beyond'.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw two areas of outstanding practice:

- The practice was classed as a POCT (point of care testing) hub practice within the locality, and alongside

Summary of findings

six other practices was offering patients additional services not normally found within a GP setting. For example, the Red House Surgery was able to offer D-dimer and deep vein thrombosis (DVT) testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).

- A specialist nurse for patients with learning disabilities was available to offer support and conduct health checks. At the time of our inspection there were 56 patients on the learning disability register supported by this nurse.

The area where the provider should make improvement is:

- Continue with efforts to improve the support offered to patients with dementia and actively encourage patients to attend regular reviews.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons learnt were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received support, an explanation of events, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The practice maintained effective working relationships with other safeguarding partners such as health visitors.
- There were appropriate systems in place to protect patients from the risks associated with medicines management and infection control.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were largely at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Clinical staff were aware of the process used at the practice to obtain patient consent and were knowledgeable on the requirements of the Mental Capacity Act (2005).
- The practice was proactive in encouraging patients to attend national screening programmes for cervical, breast and bowel cancer.

Good



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Data from the national GP patient survey published in January 2016 showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- A specialist nurse for patients with learning disabilities was available to offer support and conduct health checks. At the time of our inspection there were 56 patients on the learning disability register supported by this nurse.
- The practice held a register of patients identified as carers.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Milton Keynes Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice took an innovative approach to developing systems to improve communications and access across the locality. They had been the first practice to convert to specific computer software and had been instrumental in encouraging other practices to convert their systems ensuring information could be shared easily.
- The practice was classed as a POCT (point of care testing) hub practice within the locality, and alongside six other practices was offering patients additional services not normally found within a GP setting. For example, the Red House Surgery was able to offer D-dimer and deep vein thrombosis (DVT) testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Summary of findings

- A Phlebotomy clinic ran daily enabling patients to have blood tests conducted locally rather than at the local hospital.

Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Good



Summary of findings

The six population groups and what we found

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

Older people

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice supported frail elderly patients in local nursing and residential homes.
- The practice provided influenza, pneumonia and shingles vaccinations.
- A phlebotomy clinic ran daily enabling patients to have blood tests conducted locally rather than at the local hospital.
- The practice offered health checks for patients over the age of 75.
- All patients over the age of 75 had a named GP.
- A member of the patient participation group (PPG) was the Older Person Champion for the locality and was available to support people in attending local groups when needed.

Good



People with long term conditions

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was comparable to the clinical commissioning group (CCG) and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last blood glucose reading showed good control in the preceding 12 months, was 72%, where the CCG average was 74% and the national average was 78%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice was involved in a pilot scheme with the British Lung Foundation (BLF) to improve the respiratory function of

Good



Summary of findings

patients with COPD. The practice had written to a specific group of patients encouraging them to attend a local 12 week programme to improve their diet and lifestyle in an effort to improve their health.

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 83%, which was comparable to the CCG average and national averages of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- Family planning and contraceptive advice was available.
- The practice had provided classes for children and their families to teach them how to use their inhalers.

Good



Working age people (including those recently retired and students)

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice provided health checks to all new patients and carried out routine NHS health checks for patients aged 40-74 years.
- Pre-bookable appointments were available from 7am on Thursdays.
- The practice had enrolled in the Electronic Prescribing Service (EPS) in 2015. This service enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.

Good



Summary of findings

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- A specialist nurse for patients with learning disabilities was available to offer support and conduct health checks. At the time of our inspection there were 56 patients on the learning disability register supported by this nurse.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice held palliative care meetings in accordance with the national gold standards framework involving district nurses, GP's and the local Willen Hospice nurses.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice had identified 1.5% of the practice list as carers. The practice made efforts to identify and support carers in their population.
- Two members of staff had been trained as Carers Champions
- The practice worked collaboratively with another local practice to promote the Living in the Moment Group, which ran from a local community hall. The group offered support and advice to people who found themselves feeling isolated or lonely.
- The practice was involved in supporting patients recovering from cancer treatment once they were discharged from hospital care through a group called 'Cancer and Beyond'.

Good



People experiencing poor mental health (including people with dementia)

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

Good



Summary of findings

- The percentage of patients with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to 31/03/2015) was 61% where the CCG average was 78% and the national average was 84%.
- The practice supported patients with dementia and we saw that several members of staff had undergone additional training to become dementia friends. These staff members wore badges to make them easily identifiable to patient requiring additional support.
- Performance for mental health related indicators were otherwise comparable to local and national averages. For example, the percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 84% where the CCG average was 86% and the national average was 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages. 256 survey forms were distributed and 117 were returned. This represented 0.9% of the practice's patient list (a response rate of 46%).

- 82% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 59% and national average of 73%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 75% and national average of 76%.
- 96% of patients described the overall experience of this GP practice as good compared to the CCG average of 76% and national average of 85%.
- 95% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 69% and national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 24 comment cards which were all positive about the standard of care received. In particular, patients commented on the caring and empathetic attitude of staff and excellent standard of care patients felt they received.

We spoke with six patients and the Deputy Chair of the patient participation group (PPG) during the inspection. (The PPG is a group of patients who work with the practice to discuss and develop the services provided). All informed us that they were highly satisfied with the care they received and thought staff were approachable, committed and caring.

The practice also sought patient feedback by utilising the NHS Friends and Family test. The NHS Friends and Family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. Results from January 2016 to March 2016 showed that 88% of patients who had responded were either 'extremely likely' or 'likely' to recommend the practice.

The Red House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Red House Surgery

The Red House Surgery provides a range of primary medical services, including minor surgical procedures from its location on Queensway in Bletchley, Milton Keynes.

The practice serves a population of approximately 13,600 patients with slightly higher than average populations of females aged 65 to 69 years. There are marginally lower than average populations of patients aged 5 to 24 years. The practice population is largely White British. National data indicates the area served is one of average deprivation in comparison to England as a whole.

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

The practice operates from a three storey converted property and patient consultations and treatments take

place on the ground level and first floor. There is a car park to the rear of the surgery, which is shared with the neighbouring pharmacy, with adequate disabled parking available.

The Red House Surgery is open between 8am and 6.30pm Monday to Friday. In addition, pre-bookable appointments are available from 7am on Thursdays.

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 8 June 2016.

During our inspection we:

Detailed findings

- Spoke with a range of staff including three GP partners, a nurse, a health care assistant, the practice manager and members of the administrative team.
- Spoke with patients who used the service and representatives of the patient participation group (PPG).
- Observed how staff interacted with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident reporting form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation of events, a written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, we saw that when an error in vaccine administration occurred the practice was prompt to respond and take appropriate action to ensure the affected patients were not at risk. A full investigation was undertaken and the patients received a formal written apology. Learning was shared within the practice to reduce the risk of recurrence.
- The practice maintained a log of significant events and they were discussed as a standing item on the agenda for weekly clinical meetings and monthly practice meetings, to ensure that lessons learnt were shared and monitored.

We reviewed safety records, incident reports, MHRA (Medicines and Healthcare products Regulatory Agency) alerts, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons learnt were shared and action was taken to improve safety in the practice. For example, we saw that an alert was received regarding a medicine used for the treatment of nausea and sickness. The practice contacted all patients affected by the alert and changed their prescriptions accordingly to ensure they were not at risk. We also saw evidence that a public health report was received regarding changes to the Meningitis C vaccination. This was distributed to all staff and protocols were updated to ensure the most recent guidance was being followed.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a GP lead for safeguarding who was supported by a deputy second GP and two members of the administrative team. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. For example, we saw that the practice had responded to an information request from the local authority regarding the care and welfare of an older person in an appropriate and timely manner. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to the appropriate level to manage child (level 3) and adult safeguarding.
- Notices in the waiting rooms and clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention team to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken and we saw evidence that action had been taken to address any improvements identified as a result. For example, we saw that treatment couches had been replaced following audits conducted.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).

Are services safe?

Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) medicines management team, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants (HCAs) were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy available with a poster in the staff kitchen which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. Fire alarms were tested weekly and the practice had a variety of other risk assessments in place to monitor safety of the premises such as Control of Substances

Hazardous to Health (COSHH), infection control and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- All electrical equipment was checked annually to ensure the equipment was safe to use and clinical equipment had been checked in June 2015 to ensure it was working properly. We saw that testing was scheduled again for July 2016.
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff informed us they worked flexibly as a team and provided additional cover if necessary during holidays and absences.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for key suppliers and stakeholder organisations.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date through regular meetings and discussions. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. For example, we saw evidence that following an update to NICE guidance on nutrition advice for patients with chronic obstructive pulmonary disease (COPD) the practice had introduced information leaflets for these patients incorporating updated advice.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 95% of the total number of points available.

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

Performance for diabetes related indicators was comparable to the clinical commissioning group (CCG) and national averages. For example,

- the percentage of patients with diabetes, on the register, in whom the last blood glucose reading showed good control in the preceding 12 months was 72%, where the CCG average was 74% and the national average was 78%. Exception reporting for this indicator was 4% compared to a CCG average of 13% and national average of 12%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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

- The percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 84% where the CCG average was 86% and the national average was 88%. Exception reporting for this indicator was 3% compared to a CCG average of 19% and national average of 13%.
- The percentage of patients with hypertension having regular blood pressure tests was 79% which was comparable to the CCG average of 81% and national average of 84%. Exception reporting for this indicator was 3% compared to a CCG average of 6% and national average of 4%.

This practice was an outlier for one area of QOF clinical targets:

- The percentage of patients with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to 31/03/2015) was 61% where the CCG average was 78% and the national average was 84%. Exception reporting was 8% compared to a CCG average of 9% and national average of 8%.

The practice was aware that this was a wide deviation and was making efforts to improve their review processes for these patients. The practice was proactive in supporting patients with dementia and we saw that several members of staff had undergone additional training to become dementia friends. These staff members wore badges to make them easily identifiable to patient requiring additional support.

We saw that audits of clinical practice were undertaken, with six audits having been undertaken in the last two years. Examples of audits included

- A review of asthma patients to monitor their use of specific medicines to ensure they were not being over prescribed.
- The practice also identified patients who were at risk of over using their prescribed medicines. These patients were reviewed by the respiratory nurse to optimize their treatment.

Are services effective?

(for example, treatment is effective)

- Another audit had reviewed the appropriateness of specific testing for rheumatoid arthritis patients. The audit had resulted in a change of approach to the use of specific tests which in turn had led to improvement in the effectiveness of this testing.

The GPs told us that clinical audits were linked to medicines management information, clinical interest, safety alerts or as a result of QOF performance.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example we saw that nursing staff and health care assistants involved in reviewing patients with long term conditions such as diabetes and asthma attended regular updates and received training to support them specifically in these roles.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal in the last 12 months.
- We noted that the practice closed on ten afternoons each year to provide protected learning time for staff.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their computer system. This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs along with assessment and planning of ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. A nurse reviewed all patients admitted to hospital each month. In addition, the practice held a register of patients at risk of unplanned hospital admission or readmission. We saw that patients on this register and any others who had been recently admitted or discharged from hospital were discussed at monthly multi-disciplinary team (MDT) meetings when needed. At the time of our inspection there were 215 patients on the risk of unplanned admission register. We saw evidence that these patients had personalised care plans which were routinely reviewed and updated.
- The practice held MDT meetings that made use of the gold standards framework (for palliative care) to discuss all patients on the palliative care register and to update their records accordingly to formalise care agreements. A GP lead reviewed all patients on the register and provided typed notes which were circulated to the clinical staff prior to each meeting. They liaised with district nurses, Willen Hospice nurses and local support services. A list of the practice palliative care patients was also shared with the out of hours service to ensure patients' needs were recognised. At the time of our inspection 24 patients were receiving this care.

Consent to care and treatment

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

Are services effective?

(for example, treatment is effective)

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Health care assistants provided smoking cessation advice to patients with the option to refer patients to local support groups if preferred.
- Nurses trained in chronic disease management had lead roles in supporting patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).
- The practice provided contraceptive advice, including fitting of intra-uterine devices and implants.
- All patients over 75 had a named GP.
- The practice was involved in a pilot scheme with the British Lung Foundation (BLF) to improve the respiratory function of patients with COPD. The practice had written to a specific group of patients encouraging them to attend a local 12 week programme to improve their diet and lifestyle in an effort to improve their health.
- The practice had provided classes for children and their families to teach them how to use their inhalers

themselves. This was led by a respiratory nurse in an effort to reduce the risk of children becoming ill when left in the care of others during summer holidays and camps.

The practice's uptake for the cervical screening programme was 83%, which was comparable to the CCG average and national averages of 82%. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and information for those with a learning disability and they ensured a female sample taker was available.

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

- 58% of patients aged 60-69 years had been screened for bowel cancer in the preceding 30 months, where the CCG average was 56% and the national average was 58%.
- 70% of female patients aged 50 to 70 years had been screened for breast cancer in the preceding 3 years, where the CCG average was 74% and the national average was 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 79% to 95% and five year olds from 88% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, patients over 75 years old and NHS health checks for patients aged 40-74. At the time of our inspection for the period January 2013 to May 2016 the practice had completed 1,980 of 4,267 (46%) eligible health checks for people aged 40 to 74 years. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 24 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

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

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 77% and national average of 85%.

- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and national average of 82%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.
- A hearing loop was available for patients who suffered from impaired hearing.
- A specialist nurse for patients with learning disabilities was available to offer support and conduct health checks. At the time of our inspection there were 56 patients on the learning disability register supported by this nurse.

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Information about support groups was also available on the practice website. The patient participation group (PPG) were active in promoting, engaging and supporting patients in various locally run initiatives to offer support, including a walking group. One member of the PPG was the Older Person Champion for the locality and was available to support people in attending local groups when needed.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 202 patients as carers (1.5% of the practice list). Two members of staff had recently trained as Carers Champions and were able to signpost patients to suitable support organisations. A noticeboard in the waiting room also provided written information to direct carers to the various avenues of support available to them. The practice identified that they

were not always using appropriate computer software codes to help them identify these patients and informed us that they intended to improve their systems to ensure all patients who were carers could easily be identified.

The practice worked with another local practice and a group called 'Cancer and Beyond' and supported people recovering from Cancer once they had been discharged from hospital or other clinical services. In particular they aimed to provide support on returning to work, financial concerns and emotional support in coming to terms with difficult periods of illness. The practice was also working collaboratively with another local practice to promote the Living in the Moment Group, which ran from a local community hall. The group offered support and advice to people who found themselves feeling isolated or lonely.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Milton Keynes Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice took an innovative approach to developing systems to improve communications and access across the locality. They had been the first practice to convert to specific computer software and had been instrumental in encouraging other practices to convert their systems ensuring information could be shared easily.

- The practice offered an early morning clinic on Thursdays between 7am and 8am for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- A phlebotomy clinic ran daily enabling patients to have blood tests conducted locally rather than at the local hospital.
- There were disabled facilities, a hearing loop and translation services available.
- The practice had installed a lift to improve access and we saw that patients who required assistance were helped when needed.
- The practice worked with another local practice and a group called 'Cancer and Beyond' and supported people recovering from Cancer once they had been discharged from hospital or other clinical services. In particular they aimed to provide support on returning to work, financial concerns and emotional support in coming to terms with difficult periods of illness.
- The practice were keen to engage with younger patients and we were told of plans for a local HealthWatch Youth Group to attend the practice and provide feedback on what young people want with regard to GP services and general health requirements.

- There was a lead GP and nurse for diabetic care and the practice was able to offer an insulin initiation service.
- The practice was classed as a POCT (point of care testing) hub practice within the locality, and alongside six other practices was offering patients additional services not normally found within a GP setting. For example, the Red House Surgery was able to offer D-dimer and deep vein thrombosis (DVT) testing for patients. (D-dimer tests are used to rule out the presence of a blood clot). The practice was able to receive referrals from other practices across the locality to provide these services to patients outside their own practice population.
- The practice had enrolled in the Electronic Prescribing Service (EPS) in 2015. This service enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.
- The practice supported frail elderly patients in local nursing and residential homes.
- The practice ran an anticoagulant clinic for patients to monitor their treatment. (Anticoagulants are medicines used to prevent blood from clotting).

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. In addition, pre-bookable appointments were available from 7am on Thursdays. The out of hours service was provided by Milton Keynes Urgent Care Services and accessed via the NHS 111 service. Information about this was available in the practice and on the practice website. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. Appointments could be accessed online, via the telephone and by booking in person.

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

- 88% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 78%.
- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 59% and national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

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

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

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

Listening and learning from concerns and complaints

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

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

We looked at 43 complaints received since April 2015 and found they had been dealt with in an open and timely way. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, we saw evidence that additional training was offered to reception staff following a complaint from a patient regarding the processing of their prescription. The patient also received a written apology from the practice.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to provide a high quality GP service to its patient population. It promoted an ethos amongst staff to treat others how they would like themselves and their family or friends to be treated. The practice recognised the need to work alongside colleagues in secondary care and at the Milton Keynes Clinical Commissioning Group (CCG) within their financial constraints to deliver this service. Staff we spoke with understood these aims and demonstrated their commitment to achieve them.

Whilst the practice did not have a formal business plan, GP partners and managers were able to discuss the plans for the future and we saw evidence of regular partners meetings that were held, incorporating discussions around future planning. We saw evidence of forward thinking to maintain the smooth running of the practice and ensure patient care was not compromised. For example, the practice had ceased to accept new patient registrations in August 2015 (with approval from NHS England and the Milton Keynes Clinical Commissioning Group) as it had reached its clinical capacity.

The practice recognised that it had outgrown its premises and we saw evidence that the practice was in discussions with local stakeholders to secure more suitable accommodation. We were told of plans to expand health services available to the local population once new premises were secured.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. We spoke with clinical and non-clinical members of staff who demonstrated a clear understanding of their roles and responsibilities.
- Practice specific policies were implemented and were available to all staff via the computer system. We looked at a sample of policies and found them to be available and up to date.

- A comprehensive understanding of the performance of the practice was maintained using the Quality and Outcomes Framework (QOF) and other performance indicators. We saw that QOF data was regularly discussed and actions taken to maintain or improve outcomes for patients.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. We looked at examples of significant event and incident reporting and actions taken as a consequence. Staff were able to describe how changes had been made or were planned to be implemented in the practice as a result of reviewing significant events.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

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

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

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

- Staff told us the practice held regular team meetings and we saw evidence of regular formal communications between the practice team.

Are services well-led?

Good 

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We were told of regular social events for staff held throughout the year.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. For example, we were told of efforts made to improve care for patients suffering with leg ulcers by providing further training for some nurses so that they could provide an advanced service, as recommended by a member of the nursing team.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had proposed changing the entry door into the practice for an automatic door to improve access for patients in wheelchairs, those with limited mobility and for those using pushchairs. The practice was quick to respond and installed an automatic push button on the door.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

- The practice was also planning to gather feedback from a local HealthWatch Youth Group on what young people want with regard to GP services and general health requirements.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was classed as a POCT (point of care testing) hub practice within the locality, and alongside six other practices was offering patients additional services not normally found within a GP setting. For example, the Red House Surgery was able to offer D-dimer and deep vein thrombosis (DVT) testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).

The practice prided itself of its innovative approach and described how it was often at the forefront of various pilot schemes that had been introduced across the locality. For example, the practice was the first to pilot an electronic system for managing pathology results, enabling them to be sent electronically directly to GPs for review. Similarly the practice was first to pilot the use of electronic discharge summaries and was earmarked to pilot a new system for processing hospital letters for both Milton Keynes General and Stoke Mandeville Hospitals.

The practice was also keen to engage with local initiatives to support patients. For example, the practice was involved in supporting patients recovering from cancer treatment once they were discharged from hospital care through a group called 'Cancer and Beyond'.

The practice had recognised existing challenges and potential future threats to its financial security and ability to continue providing services. In 2014 the practice joined a federation known as Roundabout Health. (A federation is the term given to a group of GP practices coming together in collaboration to share costs and resources or as a vehicle to bid for enhanced services contracts). Through collaborative working with other practices in the federation the practice had been able to secure its future.