

# Stony Medical Centre

## Quality Report

The Health Centre, Market Square,  
Stony Stratford, Milton Keynes, MK11 1YA  
Tel: 01908 260382  
Website: [www.stonymedicalcentre.co.uk](http://www.stonymedicalcentre.co.uk)

Date of inspection visit: 5 January 2016  
Date of publication: 18/02/2016

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

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	10

### Detailed findings from this inspection

Our inspection team	11
Background to Stony Medical Centre	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Stony Medical Centre on 5 January 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 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.
- Patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

- The practice engaged with the CCG to provide additional services to improve outcomes for patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice recognised the needs of vulnerable patients aged over 75 and provided them with tailored care and support through a nurse led case management project.
- 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 involved in two pilot schemes providing two Primary Care Outpatient Clinics (PCOCs) for dermatology and gynaecology enabling patients across the locality (including those registered at other practices) to receive services they would normally only receive in secondary care.
- The practice was one of seven POCT (point of care testing) hub practices in the locality, enabling them to receive referrals from other practices to provide

# Summary of findings

patient care that would normally be provided in a secondary care setting. For example, the practice were able to test patients presenting symptoms of blood clots.

However, there was one area where the provider should make improvement:

- To review arrangements for the security of emergency medicines when the practice is closed to ensure newly implemented systems are sustained.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and 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.
- Risks to patients were assessed and well managed.
- While emergency medicines were stored securely during practice open times the practice could not be assured they were stored securely when the practice was closed and took immediate action to address this.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and 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 for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. For example, meeting with nurses from the local hospice to support patients requiring end of life care.

### Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the National GP Patient Survey showed patients rated the practice in line with local and national averages for several aspects of care.

# Summary of findings

- 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 also saw that staff treated patients with kindness and respect, and maintained confidentiality.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Staff reviewed the needs of the local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice was one of seven POCT (point of care testing) hub practices in the locality which enabled them to receive referrals from other practices to provide patient care that would normally be provided in a secondary care setting. For example, the practice were able to offer D-dimer testing for patients. (D-dimer tests are used to rule out the presence of a blood clot).
- The practice was also involved in CCG pilot schemes, providing two Primary Care Outpatient Clinics (PCOCs) for dermatology and gynaecology.
- The practice assessed the needs of its patient population and initiated services to meet their requirements. For example, the practice had recognised that vulnerable patients over the age of 75 would benefit from additional provision. A nurse led case management project was introduced to provide tailored care and support to these patients.
- Patients said they were able to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



## Are services well-led?

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

- The practice had a clear vision to provide a high quality GP service to its patient population. Staff were clear about the vision and their responsibilities in relation to this.

Good



# Summary of findings

- 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 knowing about 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.

# 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.
- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Vulnerable patients over the age of 75 benefitted from a nurse led case management project which provided them with tailored care and support, including referrals to third sector support such as Age UK.
- Flu vaccination rates for the over 65s were 74.7% compared to the national average of 73.2%.

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 higher than the national average. For example, the percentage of patients on the diabetes register, with a record of having had a foot examination and that had been risk classified within the preceding 12 months was 93.7% compared to the national average was 88.3%.
- 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.

Good



### 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

Good



# Summary of findings

example, the GP safeguarding lead liaised and met regularly with the health visitor to discuss issues and concerns about a child and how they could be supported. 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 85%, which was higher than the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice provided enhanced gynaecology services to patients through its involvement in the PCOC (Primary Care Outpatient Clinics) enabling patients to receive care within the practice rather than through referral to secondary care services.

## **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 was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice was registered with the electronic prescribing service (EPS).
- Patients were able to book appointments with GPs and nurses online.

**Good**



## **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.
- Electronic records alerted staff to patients requiring additional assistance.
- The practice telephoned patients with a learning disability to invite them to annual face to face reviews.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

**Good**





# Summary of findings

- The practice informed 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)

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

- There were 54 patients on the dementia register, of which 43 had received face to face reviews in the last 12 months, seven had appointments scheduled for reviews to be completed.
- The practice regularly worked with multi-disciplinary teams in the case management of people 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 received regular training and had a good understanding of how to support patients with mental health needs and dementia.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results published in July 2015 (data collected from January – March 2015 and July – September 2014) showed the practice was generally performing in line with local and national averages in relation to care and treatment received. There were 113 responses which represents 0.99% of the practice population.

- 64.3% found it easy to get through to this surgery by phone compared to a CCG average of 58% and a national average of 73.3%.
- 85.9% were able to get an appointment to see or speak to someone the last time they tried (CCG average 80.7%, national average 85.2%).
- 75% described the overall experience of their GP surgery as fairly good or very good (CCG average 77%, national average 84.8%).
- 73.1% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 69.8%, national average 77.5%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards which were predominantly positive about the standard of care received. Two of the comments cards received stated that the wait time for booking a routine appointment was sometimes considerable although these patients did also comment that they were always able to book urgent appointments.

We spoke with six patients during the inspection. All of these patients said they were happy with the care they received and thought staff were approachable, committed and caring. There were comments from some patients that they often had to wait more than 20 minutes to be seen for their appointments, however, the majority also stated that they were always given adequate time during their appointments to discuss their concerns.

# Stony Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP specialist advisor. A second CQC inspector attended for the morning of the inspection.

## Background to Stony Medical Centre

Stony Medical Centre provides a range of primary medical services from its location at The Health Centre, Market square, Stony Stratford, Milton Keynes, MK11 1YA, the first purpose built health centre in Milton Keynes, having opened in 1974. The building is owned by NHS property services and the practice shares these premises with another GP practice and Trust community staff. The practice serves a population of approximately 11388 patients with higher than average populations of both males and females aged 49 to 74 and lower than average populations aged 0 to 39 years. The practice population is largely white British. National data indicates the area served is less deprived in comparison to England as a whole.

The clinical staff team consists of two male and four female GP partners, a female salaried GP, one trainee GP five nurses and five health care assistants. Trainee GPs are qualified doctors training to become GPs. The team is supported by a business manager and a team of administrative support staff. The practice holds a GMS contract for providing services and is a training practice with one GP registrar who we did not meet on the day of our inspection.

The practice is open from 8am to 6.30pm Monday to Friday. In addition to these times, the practice operates extended hours on Tuesdays and Thursdays from 6.30pm to 7.30pm and from 8am to 12pm on Saturdays. Patients requiring a GP outside of normal hours are advised to phone the NHS 111 service.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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 visit on 5 January 2016. During our inspection we:

- Spoke with a range of staff including three GP partners, the nurse manager, three additional nurses, the business manager and members of the administrative team. We spoke with six patients who used the service and a representative of the patient participation group (the PPG is a group of patients who work with the practice to discuss and develop the services provided).

# Detailed findings

- Observed how staff interacted with 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 business manager of any incidents and there was a recording form available on the practice's computer system. A log of significant events was maintained by the business manager. Significant events were discussed at weekly practice meetings between clinical staff and the business manager. We saw evidence that significant event review meetings were held twice a year and that the practice carried out a thorough analysis of the significant events.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

National patient safety and medicines alerts were received into the practice by email to the business manager who cascaded information to relevant staff. We saw that safety alerts were discussed at weekly practice meetings and that appropriate action was taken when necessary to ensure patient safety was maintained.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

### 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 them from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and 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. One of the GPs was identified as the lead member for safeguarding and she was supported by a health care assistant who offered administrative support. The practice held regular safeguarding meetings with health visitors and we saw evidence of the practice providing reports where

necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. All GPs were trained to safeguarding level three in relation to safeguarding children.

- A notice on the television screen in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (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. Central and North West London Trust (CNWL) employed external cleaners and had responsibility for general cleaning of the practice area. The nurse manager was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, the practice had changed fabric seating in the clinical rooms to seats with non-porous covers.
- We checked medicines stored in refrigerators and found they were stored securely. There was a policy for ensuring medicines were stored at the correct temperature and records showed fridge temperature checks were carried out ensuring medicines were stored at the correct temperature. Medicines were checked regularly to ensure they were in date and rotated. The nurses and health care assistants (HCAs) used patient Group Directions (PGDs) and Patient Specific Directions (PSDs) to administer vaccines that had been produced in line with legal requirements and national guidance. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. No controlled drugs were kept at the practice. There was a

## Are services safe?

clear system to monitor repeat prescriptions which was managed by the prescription clerk, who ensured that medicines requiring authorization from a GP were processed appropriately.

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. The practice building was managed by NHS property services who had subcontracted maintenance of the building to the Central and North West London Trust (CNWL). The practice had up to date fire risk assessments and CNWL carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw evidence that CNWL had conducted a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The business manager carried out regular visual checks of the practice environment and shared identified risks with NHS property services to ensure they were addressed.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota for all the different staffing groups and annual leave rules in place to ensure that enough staff were on duty. We were told that administrative staff were multi skilled and could cover additional roles if needed. The staff we spoke with told us they worked well as a team and felt competent to fulfil their duties.

### 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 those we spoke with said they felt confident in their knowledge of what to do in an emergency.
- The practice had a defibrillator available on the premises with adult and children's pads ready for use and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff on an emergency trolley that was stored securely in the reception office and all staff knew of their location. All the medicines we checked were in date and fit for use. The practice left the trolley in the reception office at all times and although it had a lock, it was observed that the lock was broken. The practice had not risk assessed the security of the medicines on the trolley. Immediately after our inspection the practice carried out a risk assessment of the emergency trolley and changed their procedures. These changes included ensuring that the trolley was stored securely at the end of each day.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan was stored on the shared drive on the practice computers and was emailed to the personal email addresses of the GP partners and business manager. There was a cascade system in place to alert staff of practice closure and we noted the plan included emergency contact numbers for staff, in addition to other valuable information such as an IT asset list. The practice had considered various options for continuing to provide services to patients in the event of their premises being inaccessible and had made arrangements to share premises with other local practices or in the event of a longer term closure rent a local facility suitable for treating patients.

# 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 peoples' needs.

Staff demonstrated how they carried out comprehensive assessments which covered all health needs and were in line with these national and local guidelines. They were able to explain how care was planned and how patients identified as having enhanced needs, such as those with diabetes, were reviewed at regularly required intervals.

### 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 97.1% of the total number of points available, with 3.6% exception reporting. (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). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed;

- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients on the diabetes register, with a record of having had a foot examination and that had been risk classified within the preceding 12 months was 93.7% where the national average was 88.3%.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average at 87.37% where the national average was 83.5%.

- Performance for mental health related indicators was better than the national average. For example, the percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 97.2% where the national average was 88.5%.

We saw that complete cycle audits of clinical practice were undertaken. Examples of audits included audits of the prescribing of medications such as pain medication and medicines used to treat depression to ensure that these medicines were being prescribed appropriately. We also saw an audit of the telephone triage system to establish if there were any areas that the service could be improved. The GPs told us that clinical audits were linked to medicines management information, clinical interest, safety alerts or as a result of QOF performance. All GPs participated in clinical audits creating an environment of continuous improvement and learning.

### 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. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. It also covered employee welfare and ensured that new staff were clear on pay and holiday arrangements. Staff told us they received a comprehensive induction and felt prepared for their roles. Protected learning sessions were held once a month during which the practice provided in house training or invited external trainers in where appropriate.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, those reviewing patients with long-term conditions, staff administering vaccinations and staff taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff told us they attended training days and had access to and made use of e-learning training modules where needed to maintain their knowledge and skills. Staff received mandatory training that included: safeguarding, fire procedures, basic life support and information governance awareness.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice



# Are services effective?

## (for example, treatment is effective)

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 during sessions, one-to-one meetings, appraisals, mentoring, clinical supervision and facilitation and support for revalidation of doctors. All staff had had an appraisal within the last 12 months. We saw evidence that staff were encouraged to develop their careers, for example, a receptionist was training to become a health care assistant (HCA) as other reception staff had done in the past.

### 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 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 and to assess and plan ongoing care and treatment. This included when patients moved between services, such as a referral to or discharge from hospital. Unplanned hospital admissions were reviewed by an administrator who raised them on the practice computer system as tasks for appropriate GPs to review. The practice held a register of patients at risk of unplanned hospital admission or readmission and we saw that patients on this register were discussed at weekly team meetings and multi-disciplinary meetings when needed. We saw evidence that care plans for these patients were reviewed and updated. These patients also had access to the practice's bypass number. This was a telephone line that enabled them to bypass the reception desk and allowed them to speak immediately with a GP.

The practice held a register of patients requiring end of life care. We saw that the practice held quarterly meetings with the palliative care specialist nurse and district nurse team to review patients on its palliative care register and ensure they were receiving tailored and appropriate care to

facilitate the needs of patients and their families. Regular meeting were held in the interim between clinical staff, district nurses and other health care providers where needed.

### Consent to care and treatment

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

- The practice had a Mental Capacity Policy and 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. GPs and nurses we interviewed were aware and demonstrated a good understanding of the Gillick competency test (a process to assess whether children under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge).
- 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.
- Consent forms for minor surgical procedures were used and scanned into the patient's medical records.

### Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice, including those in the last 12 months of their lives, those with long term conditions (or at risk of developing long term conditions) and carers. Smoking cessation advice was available from the health care assistants and practice nurses.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 85 %, which was higher than the national average of 82%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 100% to 87.3% and for five year olds from 98.4% to 93%. These figures do not include the new Meningitis C vaccine for which the practice was performing



## Are services effective?

(for example, treatment is effective)

in line with CCG averages at 0.8% where the CCG average was 0.7%. Flu vaccination rates for the over 65s were 74.7%, and at risk groups 51.8%. These were also comparable to national averages.

Patients had access to appropriate health assessments and checks, including NHS health checks for people aged 40–74. At the time of our inspection, for the period May 2013 to December 2015 the practice had completed 2826 of

4003 eligible health checks for the 40- 74 year olds. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. New patients completed comprehensive registration cards and were offered appropriate appointments to follow up health concerns or existing conditions.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

During our inspection we observed members of staff were courteous and 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.

Nine of the eleven 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. Two cards commented on patients' dissatisfaction when waiting for two weeks to be seen for routine appointments and occasional prolonged waiting times when attending the practice for appointments. Staff told us the practice welcomed all patients and took steps to accommodate those patients from travelling communities with no fixed residence to ensure they could register and receive care when needed.

We spoke with six patients and a member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. Patients recognised that the practice experienced high demand for its services but felt that the standard of care provided was not compromised.

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

- 81.8% said the GP was good at listening to them compared to the CCG average of 84.8% and national average of 88.6%.
- 79.2% said the GP gave them enough time (CCG average 81.3%, national average 86.6%).
- 90.4% said they had confidence and trust in the last GP they saw (CCG average 93.1%, national average 95.2%)
- 77.5% said the last GP they spoke to was good at treating them with care and concern (CCG average 79%, national average 85.1%).
- 92.5% said the last nurse they spoke to was good at treating them with care and concern (CCG average 89.1%, national average 90.4%).
- 79% said they found the receptionists at the practice helpful (CCG average 84.6%, national average 86.8%)

The practice staff informed us that demand for their services was high. The practice had a higher than average population of elderly patients and many patients suffered with multiple long term conditions. The practice had carried out an analysis of its consultations to ascertain whether improvements could be made.

### 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. Patients advised us they were able to book longer appointments if needed to discuss multiple or complex health concerns. Patient feedback on the comment cards we received was also positive and aligned with these views.

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:

- 80.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82.1% and national average of 86%.
- 74.4% said the last GP they saw was good at involving them in decisions about their care (CCG average 74.7%, national average 81.4%)
- 85% said the last nurse they saw was good at involving them in decisions about their care (CCG average 83%, national average 84.8%)

## Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. There was also a hearing loop available for patients with hearing difficulties.

### **Patient and carer support to cope emotionally with care and treatment**

Notices in the patient waiting room told patients how to access a number of support groups and organisations. For example, smoking cessation, bereavement and carers support. A television screen was used by the practice to provide information on services and support available to patients regarding safeguarding and for those with mental health concerns amongst others. A practice newsletter was updated regularly and provided patients with a variety of useful information.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 171 patients on their list as carers. Written information was available to direct carers to the various avenues of support available to them. The practice had evaluated this representation to be

low several months prior to our inspection and had initiated a targeted programme to identify carers within its populations. This included writing to the next of kin of all patients with dementia and those who lived with someone with a learning disability, as well as an addition to the practice newsletter asking patients that were carers to identify themselves to the practice. The practice informed us that they had experienced a positive response to this programme and that since introducing these measures they had seen a steady increase in the number of carers registering.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer support. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. A bereavement board in the reception office informed staff of the recently deceased so that they were aware when speaking to bereaved families.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice offered a range of enhanced services such as dementia assessments. In addition the practice worked in collaboration with the CCG to offer patients access to two pilot clinics. These clinics were referred to as Primary Care Outpatient Clinics (PCOCs) and enabled patients to receive care they would normally receive in a secondary care setting (such as a hospital) within the primary care setting at Stony Medical Centre. At the time of our inspection the practice were able to offer PCOC clinics for dermatology and gynaecology each of which was led by a GP from within the existing practice team (with an external Consultant gynaecologist supporting the gynaecology clinic). Although the scheme was running as a pilot at the time of our inspection, staff told us they had seen a positive response and that the locality had benefitted from the service as pressures on secondary care for these services had been relieved.

The practice was committed to the NHS England plan to bring treatment out of secondary care where possible and into the community. Staff informed us that the practice maintained low figures for the proportion of its patients referred to secondary care and this was largely due to efforts made by the practice to provide additional services to its patients. We saw evidence that since launching the PCOC services a total of 1065 patients, who would otherwise have been referred to secondary care, had received care at the practice. The dermatology PCOC was launched in June 2014 and since then 488 patients had been seen. The gynaecology PCOC was launched in September 2014 and 577 patients had benefitted from the service. In addition to the PCOC 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 Stony Medical Centre was able to offer D-dimer testing for patients. (D-dimer tests are used to rule out the presence of a blood clot). The

practice was able to receive referrals from other practices across the locality to provide these services to patients outside their own practice population. Since 2013 the practice had offered this service to a total of 487 patients.

The practice was rated first in Milton Keynes for their diabetic care and had been for the last three consecutive years. There was a GP lead for diabetes care who was supported by two insulin trained practice nurses, a second GP and two HCAs. The practice also dedicated administrative resources to managing their diabetic patients. We saw that patients with diabetes received an annual health check and a separate annual review at the practice, with an interim basic check at three or six months, depending on patient need. Annual health checks enabled the practice to conduct a series of blood tests for patients, the results of which were used by the practice to develop individual patient reports. Patients then received copies of these reports prior to their annual review appointments, enabling them to prepare any questions they may have for the healthcare team. Housebound patients received the same care in their homes through a home visit from one of the practice nurses. Patients who did not respond to letters inviting them for reviews received a telephone call or email to arrange an appointment. The practice had a failsafe system for ensuring that patients attended the required reviews, resorting to GPs contacting patients if all other attempts failed. In between appointments patients could contact the diabetic team at the practice via email or telephone, for reassurance, advice or to arrange additional appointments if needed. The practice was also able to initiate insulin again reducing the need to refer patients to secondary care. We saw that the practice offered tailored care based upon individual need to ensure the best possible outcomes for patients.

There were registers for patients with dementia and those with a learning disability. These patients were also invited for an annual review. The practice opted to telephone these patients and arrange appointments for them to be reviewed; at the time of our inspection 22 patients were receiving this care. There were 54 patients on the dementia register, of which 43 had received annual face to face reviews and seven had appointments scheduled for reviews to be completed.

Vulnerable patients over the age of 75 were identified by the practice and received additional care services through the practice's Case Management Project. The practice had

# Are services responsive to people's needs?

## (for example, to feedback?)

designed the project to enable one of their experienced nurses to work with the GPs at the practice and provide tailored care and support to these patients. Home visits were provided by the nurse to assess medical and social needs of patients. They received medical care in their home, with GP follow up appointments where needed. The practice was able to identify vulnerable patients and support them before they experienced a potential crisis, for example by referring them to appropriate support services, including third sector organisations such as Age UK. The project aimed to provide holistic support to patients and ensure they received appropriate care in the most suitable environment.

### Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. In addition to these times, the practice operated extended hours on Tuesdays and Thursdays from 6.30pm to 7.30pm and from 8am to 12pm on Saturdays. In addition to pre-bookable appointments, a duty doctor was able to offer urgent appointments for people that needed them from 8am to 6.30pm Monday to Friday. Telephone consultations were also offered and patients could book appointments in person, online or via the telephone. On the day of inspection we saw that urgent appointments were available that same day. The next routine pre-bookable appointment was available the following day. Nurse's clinics were also run daily by practice nurses. We found the appointment system was structured to allow GPs time to make home visits where needed and ensure that all urgent cases were seen the same day.

Appointment information was available to patients on the practice website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out of hours (OOH) service was available on the practice answerphone and website and was provided by Milton Keynes Urgent Care via the NHS 111 service.

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

- 72.8% of patients were satisfied with the practice's opening hours compared to the CCG average of 72.4% and national average of 74.9%.
- 64.3% patients said they could get through easily to the surgery by phone (CCG average 58%, national average 73.3%).

- 57.5% patients said they always or almost always see or speak to the GP they prefer (CCG average 57.2%, national average 60%).

The practice recognised the value patients place on continuity of care and as such operated with personal GP patient lists. All patients at the practice had a named GP who took overall responsibility for coordinating their care. The patients we spoke with during our inspection were aware of their named GP, although some commented they did not always see their named GP. Providing continuity of care established clear lines of clinical responsibility for clinicians to follow when coordinating their patients' care.

### 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. The television screen in the waiting area displayed information for patients wishing to make a complaint and the practice website also had guidance on how patients could raise concerns. There was a complaints form available for patients not wishing to write their own complaints letters to the practice.

We looked at 18 complaints received in the last 12 months 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 more robust administrative systems were put into place following a complaint that a patient did not receive an appointment.

The practice had a patient participation group (PPG) who met with the practice staff every six weeks, carried out surveys and made suggestions for improvements. We spoke to a representative of the PPG who told us improvements had been made as a result of their involvement, for example, the practice had installed a marker and sign to encourage patients to stand back from the reception when waiting to be seen, to improve patient confidentiality when speaking to receptionists.

# 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 aimed to do so by providing patients a locally delivered service, in a safe and holistic environment, with emphasis on continuity of care where patients all have a registered doctor. Staff we spoke with understood these aims and demonstrated their commitment to achieve them.

The practice had a business plan which reflected the vision and values and was regularly monitored. We saw evidence of forward thinking and robust succession planning in order to maintain the smooth running of the practice when GP partners left.

The practice had recognised that it was outgrowing its premises and we saw evidence that the practice was regularly reviewing its accommodation and making efforts to find more suitable premises.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. Staff at the practice were clear on the structure and understood that the GP partners were the overall decision makers strongly supported by the business manager. Clinical staff met to discuss new protocols, to review complex patient needs, keep up to date with best practice guidelines and review significant events. We saw evidence of meetings for reception and administrative staff, where discussion and learning occurred. Partners and the business manager met regularly to look at the overall operation of the service.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. We looked at a sample of policies and procedures and found that them to be available and up to date.

The practice used the Quality and Outcomes Framework (QOF) and other performance indicators to measure their performance. The GPs and senior management staff we spoke with told us that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes for patients.

The practice had completed full cycle clinical audits to evaluate the operation of the service and the care and treatment given. A discussion with the GPs and evidence provided showed improvements had been made to the operation of the service as a result of audits undertaken.

The practice had a system in place for identifying, recording and managing risks. We looked at examples of significant incident reporting and actions taken as a consequence. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events.

### Leadership and culture

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

The provider was aware of and 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 knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.

There was a leadership structure in place with clear lines of accountability. We spoke with clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or as they occurred with the business manager, patient services manager or a GP partner. The business manager sent regular staff updates via email to all staff to ensure they were informed and up to date with practice activity. Staff told us they felt the practice was well managed.

### 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'



# Are services well-led?

Good 

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

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. Members of the PPG had observed the practice on a variety of days and at different times to help the practice identify any trends and areas in need of improvement. The practice had actioned their recommendations, for example by implementing measures to improve patient confidentiality at the reception desk. Patients could leave comments and suggestions about the service via the website or suggestions box in the waiting room. The practice also sought patient feedback by utilising the 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 June to August 2015 showed that 91% of patients who had responded were either 'extremely likely' or 'likely' to recommend the practice.

## Continuous improvement

There was a strong 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. For example, the practice was providing two Primary Care Outpatient Clinics (PCOCs) to enable patients to receive dermatology and gynaecology services they would normally receive in a secondary care setting (such as a hospital) within the primary care setting at Stony Medical Centre.

The practice had recognised existing challenges and potential future threats to its financial security and ability to continue providing services. In December 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.

There was a local development underway to develop 6500 new homes and the practice had quickly recognised the potential risk a high influx of new patients could pose. Staff and members of the patient participation group (PPG) had engaged in discussions with the local MP and CCG to ensure that the practice was not earmarked to deliver services to new residents of this development, and to remove this potential threat.

The practice were proactive in identifying any areas and services they felt they could expand and introduced services and measures to improve outcomes for patients. For example, they had developed a Case Management Project to provide tailored care and support to vulnerable patients over the age of 75. The practice was also keen to offer more support to carers within its population. After carrying out an analysis of the number of carers registered it had initiated a targeted effort to identify more patients as carers.