Dr Lindsay Mackenzie

Quality Report

Wootton Vale Healthy Living Centre
Fields Road
Wootton
Bedfordshire
MK43 9JJ
Tel: 01234 762500
Website:www.woottonvale.com

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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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wootton Vale Healthy Living Centre; Dr Lindsay Mackenzie on 27 April 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.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Feedback from patients about their care was consistently positive.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs.
- The practice had good facilities and was well equipped to treat patients.
- The practice actively reviewed complaints and assessed how they were managed. They responded to complaints, ensuring improvements and changes took place as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The provider was aware of and complied with the requirements of the duty of candour.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw several areas of outstanding practice including:

Summary of findings

The practice employed two healthcare coordinators. This role provided the link between clinicians and patients to offer support and advice in areas such as smoking cessation, support for patients diagnosed with cancer, referring patients to secondary care and identifying and supporting carers.

The practice's vision is to facilitate provision of care and services in a community setting. We saw numerous examples of how it has achieved this including the following:

- The lead GP had undertaken a redesign of the clinical team to ensure a quality service was provided and had developed a Women's Health Practitioner role to support women's health and provide sexual health advice to men and women.
- The practice managed an integrated gynaecology service, commissioned by Bedfordshire Clinical Commissioning Group (BCCG) for surrounding practices. This service allows women to receive treatment and tests in a primary care setting, reducing the need for hospital attendance with the exception of surgical procedures.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- 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 things went wrong patients received reasonable support and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had robust processes for infection control.
- 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.
- Staff had received training appropriate to their role and relevant pre-employment checks had been completed.
- Emergency medicines and oxygen were available.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were 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.
- The practice had introduced a robust system of competencies for staff to complete that included patient feedback.
- 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.
- The practice provided clinical space to a number of community services and staff, such as dermatology and a Parkinson's nurse.
- There was a multi-agency special notes sharing process with the out of hours service and hospital to ensure patients' needs were recognised.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice held a register of carers and was actively looking to identify patients who may have caring responsibilities, including young people, to offer support.
- A condolence card was sent to carers who had suffered a bereavement, which contained useful information on bereavement support.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Bedfordshire Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice organised regular multi-disciplinary meetings to share information regarding vulnerable adults or children.
- 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.
- The practice offered evening appointments and telephone consultations for patients unable to attend the practice during normal hours.
- 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.
- Dementia screening was undertaken for patients at risk and annual reviews were performed on diagnosed patients.
- The practice employed two health care coordinators to support the clinical team and to provide an interface between patient and clinician.

Summary of findings

- The practice managed an integrated gynaecology service, commissioned by Bedfordshire Clinical Commissioning Group (BCCG), for surrounding practices. This service enabled women to receive treatment and tests in a primary care setting, only needing to attend hospital for surgery.
- The practice had developed a Women's Health Practitioner role to support women's health and provide sexual health advice to men and women.

Are services well-led?

Good

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.
- The lead GP had undertaken a redesign of the clinical team and developed a Women's Health Practitioner role to support women's health and provide sexual health advice to men and women.
- 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 had an active patient participation group (PPG) who worked closely with the practice to improve the patient experience and practice systems.
- There was a strong focus on continuous learning and improvement at all levels.
- The practice had employed an assistant practitioner, who was a student nurse and was supporting her in her studies with the clinical manager acting as mentor.
- The practice worked closely with the Bedfordshire Clinical Commissioning Group and provided intelligence to help improve patient outcomes.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- 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.
- Monthly combined palliative care and unplanned hospital admission meetings were held with community services to provide a multidisciplinary package of care to these patients.
- The practice worked closely with community matron to provide care for patients in this group.
- An information sheet was available signposting older patients to services available both in the practice and externally.
- The local pharmacist provided a same day medication delivery service for patients unable to collect their medicines from the pharmacy.
- A hearing advisory service was available at the practice.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management for example, diabetes, asthma and chronic obstructive pulmonary disease (COPD) and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was higher than local and national averages. For example, the percentage of patients with diabetes, on the practice register, in whom the last HbA1c was 64mmol/mol or less in the preceding 12 months was 87% compared to local CCG average of 76% and national average of 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 more complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

- Asthma care audits were used to identify patients who would benefit from additional support and more frequent reviews.
- The practice was keen to offer support for patients suffering from neurological conditions such as, multiple sclerosis and Parkinson's disease. They liaised with specialist nurses and provided dedicated clinical space. This service was offered to patients from the practice as well as patients from the surrounding area.
- There was a robust recall system in place to monitor patients in this group.
- Patients benefitted from access to on-site specialist services. For example, access to a dedicated respiratory nurse, dermatology GP and a Women's health nurse specialist.
- NHS Health checks were used to identify patients at risk of developing long term conditions. These patients were then provided with further treatment and support as necessary.
- Dementia assessments were performed at annual reviews for patients suffering from long term conditions.

Families, children and young people

Good

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 higher 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 88%, which was higher than the CCG average of 83% and the national average 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 and health visitors, including clinics held on site and attending meetings.
- The practice frequently undertook safeguarding audits, attended monthly meetings and worked with other agencies to support children and families at risk.

Summary of findings

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice had developed a women's health practitioner role to support women's health and provide sexual health advice to men and women.
- 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.
- Late appointments and telephone advice were available for patients unable to attend the practice in normal working hours.
- In addition the practice offered the Electronic Prescription Service (EPS) and SMS text message reminders.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. They adapted services where possible to facilitate the needs of these vulnerable groups. Where appropriate used the health care coordinators to support and sign post patients.
- The practice offered longer appointments, annual reviews and personalised care plans 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.
- Patients who required additional support with drug and alcohol addictions and were unable to travel to specialist clinics were seen in the practice by local support groups for example, the Pathway 2 Recovery service.
- 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.
- Priority appointments were available for patients registered as carers, who were also offered regular health assessments.

- Electronic alerts on the clinical system ensured vulnerable patients were quickly identifiable.
- Translation services and British Sign Language (BSL) interpretation was available through an external agency.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 127 patients as carers (2.4% of the practice list) whose ages ranged from 17 to 93 years of age.
- The practice provided support to carers including offering flexible appointments and assistance with carers assessments, applying for benefits and advice on advanced care plans.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice held registers of patients suffering from poor mental health and those with dementia.
- 100% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the 12 months preceding our inspection. This was above the CCG average of 84% and the national average of 84%.
- Performance for mental health related indicators was also above local and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their patient record in the preceding 12 months was 100%;
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations, including MIND, SEND and local advocacy services.
- The practice had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health. The practice had developed a family orientated approach to mental health problems in children and parents. Safeguarding meetings were held every 6 weeks, attended by health visitors to ensure families were given support, especially in cases where women were showing signs of post-natal depression.

Summary of findings

- Staff had a good understanding of how to support patients with mental health needs and dementia.
- Mental health reviews were completed and medication monitoring systems were in place and facilitated through corroborative working with local mental health services.
- Patients could be referred to external support services for example, the lifestyle hub, cognitive behavioural therapy and addiction support services.
- The practice offered space for mental health professionals to see patients who needed to be seen in a more local environment including CALS (alcohol workers) and Changing Faces (disfigurement camouflage).
- A project was planned to screen patients for early signs of dementia and refer to services for diagnosis.

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 above local and national averages. 255 survey forms were distributed and 104 were returned, a response rate of 41%, representing 2% of the total practice population.

- 91% of patients found it easy to get through to this practice by phone compared to the CCG average of 79% and the national average of 73%.
- 81% 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 77% national average of 76%.
- 88% of patients described the overall experience of this GP practice as fairly good or very good compared to the CCG average of 87% national average of 85%.
- 84% 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 81% 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 13 comment cards, all of which were positive about the standard of care received. One card commented on a delay waiting to see the GP for their consultation.

We spoke with seven patients during the inspection. Most of the patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. We were told that patients did not always see the GP of their choice, however all were able to get an appointment to see a GP when they needed to.

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 December 2015 to July 2016 showed that 98 responses were received and 49% of patients who had responded were either 'extremely likely' or 'likely' to recommend the practice. The practice manager received and collated all FFT cards and reported back at all staff meetings and where comments made are reviewed and incorporated into action plans to be addressed alongside the practices own patient survey comments.

Outstanding practice

We saw several areas of outstanding practice including:

The practice employed two healthcare coordinators. This role provided the link between clinicians and patients to offer support and advice in areas such as smoking cessation, support for patients diagnosed with cancer, referring patients to secondary care and identifying and supporting carers.

The practice's vision is to facilitate provision of care and services in a community setting. We saw numerous examples of how it has achieved this including the following:

- The lead GP had undertaken a redesign of the clinical team to ensure a quality service was provided and had developed a Women's Health Practitioner role to support women's health and provide sexual health advice to men and women.
- The practice managed an integrated gynaecology service, commissioned by Bedfordshire Clinical Commissioning Group (BCCG) for surrounding practices. This service allows women to receive treatment and tests in a primary care setting, reducing the need for hospital attendance with the exception of surgical procedures.

Dr Lindsay Mackenzie

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, a CQC inspection manager and a practice manager specialist advisor.

Background to Dr Lindsay Mackenzie

Wootton Vale Healthy Living Centre; led by Dr Lindsay MacKenzie provide primary medical services; including minor surgery, to approximately 5,000 patients from a modular building in Wootton, Bedfordshire. Services are provided on a General Medical Services (GMS) contract which is a nationally agreed contract between general practices and NHS England for delivering general medical services to local communities.

The practice has operated from these temporary facilities since its establishment in 2006. The building serves patients on one level with sufficient consultation and treatment rooms available. Access for patients with reduced mobility and parents and/or carers using pushchairs is adequate.

The practice team serve both practices and consist of one female GP Partner, two salaried GPs; one male and one female, and several regular locum GPs. Additional clinical staff include one advanced nurse practitioner who is an independent prescriber, two practice nurses, a regular nurse locum, two health care co-ordinators; (one currently in training), a phlebotomist (currently undergoing training to become a health care assistant, an assistant practitioner who is a trainee student nurse and a clinical manager. The non-clinical team is made of a business director and an administration manager supported by 10 administrative staff.

The practice serves a lower than average population of those aged 75 years and over; approximately 4% of the practice population and higher than average population of those aged between 0 to 18 years; approximately 28% of the practice population. Approximately 10% of the population is aged below 5 years. The population is predominately white British (2013 Census data) and the area served is less deprived compared to England as a whole.

The Wootton Vale Healthy Living Centre is open between 8.15am and 12.30pm and between 2pm and 6.30pm Monday to Friday. Patients can contact reception by telephone between 8am and 6.30pm. The practice offers extended hours appointments until 8pm on Tuesdays and Thursdays. In addition, pre-bookable appointments are available between 8.30am and 11.30am Monday to Friday and between 3pm and 6pm on Monday, Tuesdays, Thursdays and Fridays. The practice offers additional clinic appointments on Tuesdays from 6.30pm until 7.40pm and on Thursdays from 6.30pm until 8pm.

The services provided at this location include midwifery, childhood immunisations, childhood surveillance, minor surgery, travel clinics, joint injections, cryotherapy, family planning, antenatal/postnatal care, sexual health, diagnostic and screening procedures, cervical screening, immunisations and minor illness.

Patients who require the services of a GP when practice is closed, are advised to contact the surgery and a recorded message gives details of how to contact the clinician on call

or the 'out of hours' service. The out of hours service is provided by Bedford Doctors on Call (BEDOC). 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 following which we carried out an announced inspection on 27 April 2016. During our inspection we:

- Spoke with a range of staff including GPs, practice nurses, the clinical manager, the practice manager and receptionists and spoke with patients who used the service including members of the patient participation group (PPG).
- Observed how patients were being cared for and treated.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation of events, a written apology and were told about any actions taken to improve processes to prevent the same thing happening again. We saw an example of when the practice identified an increase in ear, nose and throat (ENT) referrals. An investigation was carried out which identified issues within the practice's own processes. Changes were implemented which included the provision of additional patient support and education. Shared learning of improved processes were noted to reduce referral rates and improve outcomes for patients.
- The practice carried out a thorough analysis of all significant events and maintained a log of these events. These were discussed as a standing item on the agenda at monthly staff 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 an over active bladder. The practice conducted a search of all patients taking this medicine, informed them of the alert and ensured that a recent blood pressure reading had been taken, minimising the risk to these patients. All notifications were discussed at monthly meetings.

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. We saw that there were lists of key contacts in all consulting rooms, offices and reception available. There was a GP who acted as the safeguarding lead. The GP attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. For example, we saw evidence of meetings that were attended by practice staff and health visitors. The health visitor was able to access patients' records to add safeguarding information. The minutes evidenced discussions of alerts and action plans. Staff told us that they saw safeguarding as much wider than just the reporting of abuse and used the meetings to not only pre-empt risk but to offer early support if family dynamics were under stress from any cause. If needed they would access the relevant early support service as recommended by the HCC.
- The practice was proactive in arranging follow up appointments for patients of concern if they left the practice. The clinical manager was responsible for checking and following up any children who did not attend immunisation appointments and where necessary contacted relevant agencies. The GPs were trained to the appropriate level to manage child (level 3) and adult safeguarding.
- A notice in the waiting room advised patients that chaperones were available if required. Clinical 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).

Administration staff were trained as chaperones and where DBS checks had not been carried out, in the case of newly recruited members of staff, a risk assessment had been carried out.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The clinical manager was the infection control clinical lead who liaised with the local infection prevention team to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. We saw evidence that the practice had adopted good infection control measures. For example elbow operated taps, pedestal bins and laminate flooring were in all the clinical areas. The practice kept a log on the computer system for recording equipment cleaning and servicing which was easily accessible to staff.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the Bedfordshire Clinical Commissioning Group (BCCG) medicines management team to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice had a robust recall and review system in place for patients on medication that required regular monitoring.
- 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.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, interview documentation, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We also saw evidence that all staff had signed the practice confidentiality policy and had agreed employment contracts in place.

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 with a poster in the reception office which identified local health and safety representatives and an information leaflet available for patents which detailed health and safety information for patients or visitors to the practice. The practice had up to date fire risk assessments and 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. 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).
- 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, this was managed by the practice manager and the clinical manager.

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.

Good

Are services safe?

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies of this policy were kept off site in hard copy and electronically on the Bedfordshire CCG computer system.

Good

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. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- 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 100% of the total number of points available compared to the CCG and national averages of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014 -2015 showed:

- Performance for diabetes related indicators were above local and national averages. For example, the percentage of patients with diabetes, on the practice register, in whom the last HbA1c was 64mmol/mol or less in the preceding 12 months was 87% compared to local CCG average of 76% and national average of 78%. Exception reporting for this indicator was 9% compared to a CCG 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 were above local and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in their patient record in the preceding 12 months was 100% compared to the CCG average of 87% and the national average of 88%. Exception reporting for this indicator was 22% compared to a CCG average of 15% and national average of 13%.There were only 18 patients on the patient register in this group therefore the indicator was higher than expected.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 100% compared to the CCG and national averages of 84%. Exception reporting for this indicator was 7% compared to a CCG and national averages of 8%.

We discussed the above CCG and national average exception reporting for the 2014/2015 year with senior clinical staff during our inspection. We also looked at individual examples of why patients had been exempted. We found that in all the cases the practice had made every effort to review patients and the practice was able to demonstrate that exception reporting for the 2015/2016 year had reduced.

There was evidence of quality improvement including clinical audit.

- There had been 10 clinical audits completed in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- For example we saw evidence of an audit of patients taking medicine to control diabetes, the practice checked their systems to ensure that patients had been seen and their medication reviewed. The outcome showed that most patients were compliant in taking their medication and those who were not had explanations added to their records. These patients were offered additional support.
- An asthma care audit had also been completed which identified patients who would benefit from further support and an action plan put in place to provide this support.

The practice participated in local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, recent action taken as a result included an audit of safeguarding and child protection where the practice

Good

Are services effective?

(for example, treatment is effective)

identified that registers of children who may be a risk were not correct. The practice met with other agencies and developed a protocol to ensure that more robust processes were in place.

The GPs told us that clinical audits were linked to medicines management information, clinical interest, safety alerts or as a result of QOF performance. The GPs and nurses regularly reviewed the practice's QOF achievement to identify if there were any areas which required additional focus.

The clinical nurse manager held a joint clinical and administration role at the practice and was responsible for quality and performance, ensuring targets were achieved for QOF outcomes, including maintaining clinical protocols, policies and procedures. The nursing team had a number of additional roles including; managing the recall system for patients reviews, maintaining shared care records, ensuring childhood immunisation targets were reached (including following up children who did not attend) and maintaining the register of patients on high risk drugs to ensure that regular blood tests were carried out.

Effective staffing

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

- All newly appointed staff to the practice went through a period of induction where they received training relevant to their job role and essential training including safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. As part of the induction process, they had performance reviews to monitor their progress.
- Staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- The practice used a number of locums and had developed an induction pack and checklist for these staff to be familiar with the systems, policies and procedures and the practice as a whole.
- 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 within the last 12 months. The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the clinical team discussed how they could ensure a high standard of care was maintained at the practice.
- The competences were used to develop the clinicians professionally, allowing them to reflect on the care that they were giving and their patient's experience. This enabled clinicians and the management team to identify any training needs.
- 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.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information 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 professionals 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, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. There was a midwifery service in the practice and the midwife was able to update patient records on the clinical system. The practice had developed a good relationship which

encouraged information sharing regarding safeguarding and had facilitated the uptake of vaccines in pregnant women by offering ad-hoc vaccination during appointments.

The practice held regular multi-disciplinary team (MDT) meetings that made use of the Gold Standard Framework (for patients needing palliative care) to discuss all patients on the palliative care register and to update their records accordingly to formalise care agreements. They liaised with district nurses, Macmillan Hospice nurses and local support services. There was a multi-agency special notes sharing process in place to enable the out of hours service and hospital to ensure patients' needs were recognised. At the time of our inspection 19 patients were receiving this care.

Consent to care and treatment

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

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

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.

The practice's uptake for the cervical screening programme was 88%, which was better than the CCG average of 83% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice encouraged uptake of the screening programme by providing information in different languages and formats and ensuring a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice actively promoted and encouraged patients; through quarterly newsletters and practice notifications, to attend national screening programmes for bowel and breast cancer screening, this is evidenced by their above average statistics as follows;

- 73% of patients aged 60 to 69 years screened for bowel cancer in the previous 30 months against CCG average of 60% and national average of 58%.
- 83% of females aged 25 to 64 years attended breast cancer screening against CCG average of 76% and national average of 74%.

Childhood immunisation rates for the vaccinations given were comparable with CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 99% and five year olds from 93% to 99%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients 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.

All newly registered and eligible patients were offered a health check. Monthly reports were run by administrators to ensure that all eligible patients, for example those with risk factors, had been invited to attend. In 2015-2016, the practice had completed 143 of these health checks, this resulted in 12 patients being referred to healthy lifestyle programmes such as weight management and smoking cessation advice.

The practice also provided pre dementia screening for patients aged over 65 years, by using the General Practitioner Assessment of Cognition (GPCOG). All staff including GPs, practice nurses, HCAs and HCCs completed these assessments with patients during consultations. Eligible patients were highlighted to clinicians by a blue triangle on the patient's records and all staff were encouraged to perform these annually on eligible patients or patients whom they had concerns about.

Good

Are services effective?

(for example, treatment is effective)

The assessments were performed at annual reviews with patients suffering from long term conditions these were scanned into the patient record. For the period 01/04/2015 to 31/03/2016 the practice had carried out 54 assessments of which 15 patients were referred to the memory clinic of which 4 had received a confirmed diagnosis of dementia.

Good

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 13 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. Several cards commented that the extended hours appointments were helpful and that clinicians always gave good explanations of care and treatment. One card commented that sometimes appointments ran late, however all the patients we spoke to on the day told us that they did not feel rushed during their appointment.

We spoke with three members of the patient participation group (PPG). They told us that the PPG and the practice worked closely together and that they felt involved and engaged in developing the practice.

Results from the national GP patient survey published in January 2016 showed patients felt they were treated with compassion, dignity and respect. Results were above or in line with local and national averages for consultations with GPs and nurses and comparable in others. For example:

- 90% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 92% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 91% of patients said the last nurse they spoke to was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.

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:

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 92% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. The practice would use British Sign Language (BSL) services if a patient required. We saw notices in the reception areas informing patients these services were available.
- Information leaflets were available in easy read format.
- The practice published an information sheet for older patients which contained helpful lifestyle advice, details of the clinics and services the practice offered. There were also details of a number of organisations that patients might have benefitted from in regard to end of life planning, screening programmes and community services

Good

Are services caring?

- The practice had good disabled access and all rooms had couches that could be lowered. The waiting area had a good range of chairs with arms to assist patients with limited mobility.

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 Health care Co-ordinator (HCC) was available to patients through telephone access and bookable appointments to provide a listening ear, sign posting to other services, a lifestyle mentor, advocate and navigator for the patient both within and outside the practice. They provided support and through their knowledge of services referred or acted as enablers for patient self-care. They also offered extended hours access. The HCC had also recognised patients suffering from agoraphobia or obsessive compulsive disorder (OCD) were not able to attend appointments and had arranged for familiarisation and gradual exposure visits with initial access outside main surgery hours to avoid overwhelming these patients. This had given these patients confidence and familiarity with the staff so that they were able to attend appointments.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 127 patients as carers (2.4% of the practice list) whose ages ranged from 17 to 93 years of age. The practice was proactive in identifying carers and updated the register regularly. The practice recognised that there were potentially many more informal carers and had identified that searches on patient registers could be performed in an effort to identify more carers.

They were also aware that there were a number of foster parents in the area potentially acting as carers for vulnerable children and they planned to identify and support them. The practice were actively looking to identify children who may be carers to offer support to them.

Patients were identified as carers through consultations with all clinicians, at registration, new patient health checks and update forms, and by patients informing the practice. There were posters in the waiting area and on television screens and the practice useful information in practice newsletters.

Support for carers was led by the Healthcare Co-ordinators (HCC). They offered telephone consultations and face to face appointments so that issues could be discussed. The GPs and nurses were able to refer patients straight through to the HCCs for a chat after they have completed their appointment with them. This enabled prompt, effective care and support.

The practice used the flu clinics to promote services that were available to carers, by inviting services to have stalls at Saturday flu clinics or at other times in the waiting room. For example, the Alzheimer's society local advisor, a Carers in Bedfordshire worker and various other local services such as the level 3 smoking advisors.

Staff told us that if families had suffered bereavement, Health Care Co-ordinators (HCCs) 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. A condolence card was sent to the carer which contained information on bereavement support.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Bedfordshire Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had organised monthly safeguarding multi-disciplinary team meetings (MDT's) meetings, which included health visitors and the practice safeguarding lead. It was highlighted, through these meetings and a subsequent safeguarding audit that systems for sharing and alerting of safeguarding status were not always timely and robust, often resulting in delays to the practice being notified and updated. New robust systems were put in place and identified weaknesses were being investigated appropriately by outside agencies to drive improvement for the locality.

Examples of how the practice responded to patients needs included:

- The practice offered a 'Commuter's Clinic' on Tuesday and Thursday evenings until 8pm for patients who could not attend during normal opening hours. Telephone consultations were available for patients who did not require, or could not attend a face to face appointment.
- 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 and were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- 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.
- A prescription delivery service was available for patients unable to collect their own medicine.
- The practice offered on-site testing for patients including 24 hr blood pressure monitoring, 24hr heart monitoring and phlebotomy appointments.
- We were told of a number of patients who required additional support with drug and alcohol addictions who were unable to travel to specialist clinics. The Pathway 2 recovery service was able to arrange to see these patients in the practice and as a result these patients were able to receive the addiction therapy they required.
- The practice had developed a family orientated approach to mental health problems in children and parents. They had recognised that adult mental health had an impact on the whole family including children and that children's mental health issues impacted on parents. To address this they held six weekly safeguarding meetings attended by the health visitors to discuss and ensure these families were given support, especially in cases where women were showing signs of post-natal depression.
- Staff told us that they saw safeguarding as much wider than just the reporting of abuse and used the meetings to not only pre-empt risk but to offer early support if family dynamics were under stress from any cause. They would access the local early help team, and Chums for children and other services for the adults as recommended by their health care coordinators.
- The practice held a register of patients at risk of an unplanned hospital admission.
- The practice hosted a number of community services to improve access for patients, this was part of the practices strategy to bring care as close to patient as possible. These included
- Consultant community gynaecology service
- Community diabetes service, including support and education programmes
- Community hand service
- Community dermatology services
- Hearing advisor
- Pulmonary rehabilitation

The practice had higher than average numbers of patients suffering from neurological conditions mainly multiple sclerosis and Parkinson's disease and had organised a specialist nurse to see patients in the practice.

All patients who experienced poor mental health were invited for annual reviews. The practice offered space for

mental health professionals to see patients who needed to be seen in a more local environment including CALS (alcohol workers), SEND and Changing Faces (disfigurement camouflage).

All patients who experienced poor mental health were invited for annual reviews.

The practice also managed an integrated gynaecology service which was directly commissioned by Bedfordshire Clinical Commissioning Group (BCCG) for surrounding practices. This service was offered in association with a consultant from Milton Keynes Hospital. This meant that women could have all assessment and follow up care at the practice and did not need to attend hospital except for surgery.

The practice employed two health care coordinators (HCCs). Although HCCs took no clinical responsibility, they were line managed by the clinical manager. The work they performed complemented the work of the clinical staff.

This was a non clinical role and these staff supported patients by providing an interface between the patients and the clinical staff.

The HCCs supported patients by;

- Arranging carers assessments and signposting patients to organisations for example, Alzheimer's Society, Dementia Foundation, counselling services, Sight Concern, Age UK, Stroke Association, and local groups such as 'Wootton Good Neighbours' community helpers.
- Offering a listening ear to patients and their families and advising on; Living Wills, LPA and Advanced Directives, blue badge applications, council tax exemptions and other appropriate welfare advice.
- Providing continuity and accessibility to patients and proactively ensuring that vulnerable groups, carers, and those who found themselves experiencing stress, depression and crisis had someone who could navigate them to support.

The practice had developed a women's health practitioner role which supported women with neonatal and postnatal issues, adolescents, preconception and fertility care, contraception and LARC (Long Acting Reversible Contraception), menopausal problems and HRT (Hormone Replacement Therapy), and continence issues in the older patients. The practice could, with the support of this role offer advanced procedures such as diaphragms, ring pessary, and endometrial aspiration. Male patients were also offered services and treatment relating to sexual and reproductive health needs. This additional service was available during extended hours with access two evenings a week until 8pm for patients requiring evening access.

Access to the service

The practice was open between 8.15am and 6.30pm Monday to Friday. Patients were able to contact reception by telephone between 8am and 6.30pm. The practice offered extended hours appointments until 8pm on Tuesdays and Thursdays. In addition, pre-bookable appointments were available between 8.30am and 11.30am Monday to Friday and between 3pm and 6pm on Monday, Tuesdays, Thursdays and Fridays. The practice offered additional clinic appointments on Tuesdays from 6.30am until 7.40pm and on Thursdays from 6.30pm until 8pm.

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 and the practice offered a telephone triage service.

Where a patient was dependent upon their carer for appointments the practice demonstrated flexibility with regard to appointment times, access to prescriptions and ensuring that sharing permissions were in place. The Health Care Co-ordinators also offered extended hours appointments.

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

- 80% of patients were satisfied with the practice's opening hours compared to the CCG average of 80% and the national average of 78%.
- 80% of patients said they could get through easily to the practice by phone compared to the CCG average of 79% and the national average of 73%.

People told us on the day of the inspection that they found it easy to book appointments when they needed them.

The practice had a system in place to assess:

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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 and a buddy system was in place to ensure that if the designated person was not available the complaint would still be dealt with in a timely manner.
- We saw that information was available to help patients understand the complaints system; there were posters and leaflets available in the waiting area and information on the practice website.

The practice held a comprehensive log of complaints and compliments. We looked at 21 complaints received in the last 12 months and found that complaints were satisfactorily handled, dealt with in a timely way, with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. We saw evidence that when a complaint was received it was thoroughly investigated and if upheld a written apology was sent to the patients including advice as to other organisations that may be contacted for support if patients were dissatisfied with the practice response.

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 deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.

The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

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.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- 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.

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 people support 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.
- 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.
- 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.
- The practice focussed on the right roles to address the needs of the population. The lead GP had implemented an innovative approach to this by redesigning the practice team.

The practice had introduced a Women's Health Care Practitioner. This innovative role was devised by the lead GP as part of the practice workforce redesign. The practice was able to provide women with a continuity of care throughout their lives. This clinician saw women, and where relevant, their partners with problems relating to sexual and reproductive healthcare.

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 benefitted from an active Patient Participation Group (PPG) for many years. The PPG worked closely with the practice and met monthly at the practice. The majority of the meetings were attended by the practice manager and various other members of staff including the GPs and other senior members of staff attended on an ad hoc basis.

Are services well-led?

Good

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

Following feedback from patients the PPG discussed a number of areas with the practice and as a result the practice:

- Improved communication through the use of SMS services.
- Reduced patients who did not attend (DNAs).
- Offered more access to services including extended hours.
- Offered urgent access to services and a triage service.

The PPG also initiated patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG and practice had discussed concerns over the high number of failed appointments and wasted clinical time as a result. Following a survey the practice implemented a SMS text message reminder service for patients. The PPG also supported the practice's efforts to contact patients failing appointments to reduce the risk of recurrence. These combined efforts saw a marked improvement in the level of failed appointments.

A number of initiatives had been undertaken by the PPG including;

- Assisting with the development of online services and Patient Online Services. PPG members volunteered to prototype this to assist the practice in developing protocols and procedures to support this.
- They submitted articles for the quarterly Parish magazine to promote the practice and explaining what the PPG do, how they represent patients and invite new members.
- The group had their own notice board in reception containing information about the PPG, photographs of the members and their roles.

The PPG recognised that they were not fully representative of the entire practice patient demographic. They were working to find other ways such as social media and a virtual group to encourage a wider, more representative, membership

The practice had gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The lead GP was proactive in locality healthcare provision through attendance at the Locality Board. The GP also sat on committees and provided clinical support to Bedfordshire Clinical Commissioning Group (BCCG) through their role as Clinical Director. The practice contributed frequently into the BCCG soft intelligence system allowing the commissioners to monitor and improve contracts and services for the locality and improve outcomes for patients.

The practice had a caring culture and used innovative roles to meet the population groups.

The practice told us of projects planned in the near future; one to identify and support carers better especially young carers and another to screen patients for referral to dementia services for possible early diagnosis.

They had developed relationships with local foster families to better support them and the children in their care.