Haddenham Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall.

At our previous inspection in December 2014, Haddenham Medical Centre had an overall rating as Good.

Following the November 2017 inspection, the key questions are rated as:

- Are services safe? – Good
- Are services effective? – Good
- Are services caring? – Good
- Are services responsive? – Good
- Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

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

We carried out an announced comprehensive inspection at Haddenham Medical Centre in Haddenham, Buckinghamshire on 29 November 2017. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether Haddenham Medical Centre was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

At this inspection we found:

- Staff fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice had defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. For example, there was a comprehensive sepsis toolkit. Sepsis is a rare but serious complication of an infection. Without quick treatment,sepsis can lead to multiple organ failure and death. We saw there was a proactive approach to anticipate and manage the risk of sepsis. The practice had adapted existing systems to include additional escalation prompts if patients displayed potential symptoms of sepsis.

Summary of findings

- Staff had received training appropriate to their roles and the population the practice served. Any further training needs had been identified and planned.
- Our findings showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- The continued development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. We saw evidence of and staff we spoke with told us they are supported to acquire new skills and share best practice.
- We received positive feedback from external stakeholders and patients which access GP services from the practice.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. We observed the practice proactively sought feedback from staff and patients, which it acted on.
- The practice had clear and visible clinical and managerial leadership and supporting governance arrangements. There was a high level of constructive engagement with staff and all staff we spoke with told us they felt they were an integral part of the practice and they felt valued.
- There was a strong focus on continuous learning and improvement within the practice. For example, the practice was a GP teaching and training practice, supported medical students, nursing students and apprentices.
- There were two principals in the practices ethos, one was learning and development, across all staff groups and the other was a proactive approach to health promotion and prevention of ill health.

We saw areas of outstanding practice:

- The practice leadership was committed to meeting the needs of its population. This was evidenced through themed and targeted services, clinical audits and health promotion. This included a range of initiatives to meet the needs of specific groups – for example people with dementia, older people facing isolation and transport difficulties, military veterans, carers, Deaf people, travellers and the LGBT community.
- The practice had identified that there were a number of military veterans in their patient population and had taken action to help ensure this group of patients received suitable support in line with the government's armed forces covenant. The practice encouraged these patients to identify themselves through signage at the practice, military veteran information packs, information on the practice website and via questions on the 'new patient' form. As a result of the increased awareness of the armed forces covenant, there had been a significant increase in the number of patients on the military veteran register.
- Haddenham Medical Centre provided an outstanding service to patients with caring responsibilities. This service was recognised by the Carers Bucks (an independent charity to support unpaid, family carers in Buckinghamshire) and the practice was awarded an Investors in Carers GP Standard award. This was in recognition of the extra support they offer to unpaid carers who are registered at the practice.
- The practice had achieved Gold, the highest award in the NHS 'Pride in Practice' award from the Lesbian, Gay, Bisexual and Transgender Foundation. This included bespoke training for all patient facing staff which demonstrated the practice's commitment and dedication to ensuring a fully inclusive patient-centred service.

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

Haddenham Medical Centre

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 adviser.

Background to Haddenham Medical Centre

Haddenham Medical Centre provides primary medical services to the population of Haddenham Village and surrounding smaller villages. The practice is a semi-rural teaching and training practice within Aylesbury Vale Clinical Commissioning Group (CCG) and provides primary medical services to approximately 8,200 registered patients.

Services are provided from:

- Haddenham Medical Centre, Stanbridge Road, Haddenham, Buckinghamshire HP17 8JX.

The practice website is:

- www.haddenham.org

According to data from the Office for National Statistics, Buckinghamshire specifically the Haddenham area has high levels of affluence, low levels of deprivation and little ethnic diversity.

The practice population has a significantly higher proportion of patients aged over 60 when compared to the local CCG and national averages whilst there is a lower proportion of patients aged between 15-40.

The practice also provides primary care GP services for three local care and nursing home (approximately 55 patients), a local dementia care home (approximately 29 patients) and a travelling community located within the area.

Good

Are services safe?

Our findings

We rated the practice as Good for providing safe services.

Safety systems and processes

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

- The practice conducted safety risk assessments. We saw examples of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect, abuse and social/rural isolation. We saw additional support was available which aligned to the needs of the practice population, for example additional support for older people and the travelling community which accessed GP services from the practice. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. The practice had a dedicated GP as lead in safeguarding. They had been trained and could demonstrate they had the necessary knowledge to enable them to fulfil this role. They also held a lead role for safeguarding within the clinical commissioning group (CCG).
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control including yearly infection prevention control audits.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- The practice told us recruitment within the practice, specifically GP recruitment has been a challenge, however we saw suitable arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff knew how to identify patients with severe infections, for example, there was a comprehensive sepsis toolkit. Sepsis is a rare but serious complication of an infection. Without quick treatment,sepsis can lead to multiple organ failure and death. We saw there was a proactive approach to anticipate and manage the risk of sepsis. For example, the practice had adapted existing systems to include additional escalation prompts if patients displayed potential symptoms of sepsis. All staff were encouraged to participate in learning and to improve safety as much as possible, for example, staff spoke highly of the recent sepsis educational session led by one of the GPs. We saw all suspected sepsis infections were discussed at the weekly clinical meeting. Furthermore, we also saw the practice website contained key information for patients about sepsis, including the red flag symptoms and risk factors.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

Good

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. We saw the practice had reviewed and kept up to date with the latest guidance in the treatment of a diabetes related medical emergency. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship. We saw patient literature in the waiting areas which clearly explained safe and appropriate antibiotic usage.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. We saw the practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

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

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every three months to review actions from past significant events and complaints.
- We reviewed a significant event which highlighted a rare presentation of symptoms. We saw the practice had reviewed the event, national guidance and learning was shared to ensure the practice could appropriately respond if there was a similar presentation in the future.
- Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. We saw evidence that patients who had raised concerns were invited to meet with either the practice manager or a GP to discuss their concerns.
- We reviewed medicine and other safety alerts and found they were recorded, and shared with relevant staff. We saw alerts were then discussed at meetings.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as Good for providing effective services overall and for the following population groups, people with long term conditions, families children and young people, working age people (including those recently retired and students), people whose circumstances made them vulnerable and people with poor mental health (including people with dementia). The practice was rated as Outstanding for providing effective services for older people.

Effective needs assessment, care and treatment

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

We reviewed prescribing data from the local clinical commissioning group (CCG). We found the practice performed better when compared to local and national averages. For example:

- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group was 0.54. This was better when compared to the CCG average (0.68) and national average (0.98). Hypnotics, more commonly known as sleeping pills, are a class of psychoactive drugs whose primary function is to induce sleep and to be used in the treatment of insomnia, or surgical anaesthesia. Hypnotics should be used in the lowest dose possible, for the shortest duration possible and in strict accordance with their licensed indications.
- The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 0.93. This was better when compared to the CCG average (1.06) and national average (1.01). The number of antibiotic items (Cephalosporins or Quinolones) prescribed was similar (4.43%) when compared to the CCG average (4.32%) and the national average (4.71%). The practice demonstrated awareness to help prevent the development of current and future bacterial resistance. Clinical staff and prescribing data evidenced the practice prescribed antibiotics according to the principles of antimicrobial stewardship, such as prescribing antibiotics only when they were clinically needed and reviewed the continued need for them.

Older people:

- The practice provided GP services to four care and nursing homes, approximately 88 patients. Three of the care homes had a weekly GP session to review patients with non-urgent health problems; this time was also used to proactively identify and manage any emerging health issues and undertake medication reviews. The other care home is more of a residential home and is visited twice a month.
- The practice had recently completed a project reviewing patients aged 80 and over who had not been seen by a GP in the previous 12 months. As part of this project, the practice sent out letters and information packs which outlined the different services available and how to access each service. The letters and information pack were then followed up with a telephone call. This project identified 60 patients who had not seen a GP in the previous 12 months and all 60 had received an information pack and invited for an appointment which included a health check.
- Patients aged over 75 were invited for a health check. This included a medication review, annual chronic disease check, blood tests and vaccinations if required. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice had worked closely with Buckinghamshire County Council and the community practice worker team and facilitated 'Prevention Matters' events. 'Prevention Matters' was a free advice service linking eligible adults in Buckinghamshire to social activities, volunteers and community services. The programme supported people in regaining confidence and

Good

Are services effective?

(for example, treatment is effective)

independence, specifically for patients who struggle to remain independent in their own house, have difficulty getting out and about, feel lonely and isolated or recovering from an illness.

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice had recently accessed the local CCG 'over 75s' project and was already an active user. Aligned to this project the practice worked with multi-agency partners to support the care at home of vulnerable older patients in line with the Frail Older Person Strategy. The aim of this project was to prevent unplanned hospital admissions as much as possible, when necessary the practice and the project team worked to ensure that these are managed in the best possible way for the patient.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GPs and nurses worked with other health and care professionals to deliver a coordinated package of care.
- Haddenham Medical Centre was part of a local GP Development Scheme with a commitment to care and support planning for patients with long-term conditions. The practice had launched clinics for patients with diabetes, asthma and Chronic obstructive Pulmonary Disease (COPD). COPD is the name for a group of lung conditions that cause breathing difficulties. The practice told us patients with long-term conditions now received a patient centred annual health review which helped identify personal goals and targets to enhance the quality of their lives and improve health outcomes. We received written and verbal feedback from patients which praised these specific clinics and highlighted the benefit of a review of multiple conditions being reviewed at one appointment.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, each long-term condition had a designated GP as the lead and was supported by a designated nurse to support patients manage their long-term conditions.
- Performance for diabetes related indicators showed the practice had achieved 96% of targets which was similar when compared to the CCG average (92%) and the national average (91%).
- Performance for COPD related indicators showed the practice had achieved 100% of targets which was similar when compared to the CCG average (97%) and the national average (96%).
- The practice provided an anti-coagulation clinic for patients receiving a medicine used in the prevention of blood clots; this could be provided at the practice or at the patient's home. Approximately, 100 patients accessed this service and the effectiveness of this clinic was monitored through a serious of clinical audits and information collected for the Quality and Outcomes Framework (QOF). The most recent published results for 2016/17 showed that the practice was performing better in all anti-coagulation related QOF indicators when compared to local CCG and national averages.
- Patient literature was displayed throughout the practice; this included specific information to support patients with long-term conditions. For example, the practice highlighted and supplied literature for free online programmes which supported patients to make lifestyle improvements and improve their long-term condition related wellbeing.

Families, children and young people:

- Childhood immunisation rates for the vaccinations given were higher when compared to the national averages. For children under two years of age, four immunisations have performance measured per GP practice; each has a target of 90%. The practice achieved the target in all four areas; in three of the four areas the practice scored over 95%. Similarly, immunisation data for children aged five, was higher than national averages. The practice had reviewed their childhood immunisation rates and offered immunisations on a variety of days and times outside of school hours including Saturday mornings.
- The practice had arrangements to identify and review the treatment of newly pregnant women.

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

Good

Are services effective?

(for example, treatment is effective)

- The practice's uptake for cervical screening was 84%, which was similar when compared to the local CCG (82%) and national average (81%). This was a 4% increase on the previous years performance. Patients who did not attend for screening were followed up by the practice.
- The practice had systems for eligible patients to have the meningitis vaccine. The meningitis ACWY vaccines offers protection against four types of bacteria that can cause meningitis– meningococcal groups A, C, W and Y. Young teenagers, sixth formers and "fresher" students going to university for the first time are advised to have the vaccination.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Using the most recent data, we saw the practice had invited 666 patients for a health check; this exceeded the eligible population target. Out of the 666 invites, 311 health checks had been completed. We saw further data that within six months of the health check new diagnoses had been recorded. For example, there had been three cases of prediabetes (Prediabetes is where blood sugar levels are abnormally high, but lower than the threshold for diagnosing diabetes) and 76 cases of suspected hypertension (also known as high blood pressure). There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- A transient traveller community (approximately 30 patients) accessed GP services from the practice. To ensure treatment was effective the practice told us how adaptions had been made to the delivery of care for this community. For example, additional endeavour with child immunisations and a lower threshold for face to face appointments.
- Haddenham Medical Centre also provided GP services for residents at a local learning disability care home for adults. GPs visited the home when required including the provision of a flu immunisation clinic at the home to minimise potential distress for the residents.
- There were 18 patients on the Learning Disabilities register; all 18 had been invited for an annual health check. We saw 10 of the 18 (56%) had attended a health check, five had declined and the remaining three patients had been contacted via telephone on further occasions inviting them to attend a health check.

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

- 92% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher when compared to the local average (82%) and the national average (84%).
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher when compared to the local CCG average (88%) and national average (90%).
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 95% of patients experiencing poor mental health had discussed and had advice about smoking cessation. This was similar when compared to the local CCG average (94%) and national average (95%).
- A memory clinic was held at the practice every week and GPs were able to refer patients with early signs of dementia to this service.
- The practice was reviewing how effective care was delivered for people experiencing poor mental health. For example, the practice had reviewed how to maintain continuity of care for this group of patients if possible by highlighting on their notes who their usual GP was and providing information on how best to contact the GP of their choice.
- Haddenham Medical Centre worked collaboratively with the dementia care home which accessed GP services from the practice to review the care and treatment provided. For example, patients at this care home were elderly patients with multiple co-morbidities and all had

dementia. In the main this was Alzeimers dementia but a proportion of the patients had vascular dementia. In order to minimise further decline in memory, the practice reviewed and audited patients' blood pressure and introduced a schedule to continually and regularly monitor blood pressure. Maintaining blood pressure (within the target range) is paramount in controlling vascular risk factors and minimises further decline in memory.

Monitoring care and treatment

As a teaching and training practice, the practice had a long tradition of using new evidence-based techniques to support the delivery of high-quality care; we saw all staff were actively engaged in activities to monitor and improve quality and outcomes. We saw opportunities to participate in benchmarking, peer review and accreditation was pursued and staff spoke positively about the culture in the practice around quality improvement.

- Where appropriate, clinicians took part in local and national improvement initiatives. For example, we reviewed a clinical audit with regards the local CCG Primary Care Development Scheme with reference to Improving Access to Psychological Therapies (IAPT). This audit used characteristics from the national 'Five Year Forward View for Mental Health' with the main objective of the audit reviewing the referral pathways to local IAPT services.
- The practice was heavily involved in quality improvement activity; there was a quality improvement programme and a system in place for completing a wide range of clinical audit cycles. We saw the GP Partners supported the GP Registrars to complete clinical audits. To ensure consistency the practice designed a standard clinical audit template which included the reason of the audit, the criteria, agreed standard, methodology, results, learning/action points and details of the re-audit.
- The practice population had a significantly higher proportion of patients aged over 60; as a result the practice specifically audited conditions and outcomes for this group to patients to continually monitor and improve quality and outcomes. We saw completed clinical audits for managing conditions commonly found in older people, for example, a dementia audit, anticoagulation audit, and a prescribing audit which reviewed the use of antidepressants for patients 65 and over.
- Other recent clinical audits we reviewed were for prescribing, minor operations, women's health, coeliac disease and asplenism (asplenism refers to the absence of normal spleen function and is associated with some serious infection risks).

The most recent published Quality Outcome Framework (QOF) results were 97% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 96%. The overall exception reporting rate was 12% compared with the local CCG average of 8% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

We saw the practice had a comprehensive understanding of their clinical performamce, including the level of exception reporting. We saw appropriate systems in place for inviting patients to attend for their appropriate reviews and documenting when patients have been repeatedly invited verbally, by letter, or by text message. The recall system was managed by a designated member of staff. We also saw evidence that due to the older population, there was a greater proportion of patients who were removed from QOF calculations for clinically appropriate reasons, for example frail elderly and End of Life care.

Furthermore, we saw the practice was working with the CCG and introduced a care and support approach for the care of many long term conditions. As part of this plan, the practice had trained clinical members of staff in care and support planning and was a significant shift away from QOF reporting. This was reflected in the most recent QOF and exception reporting performance.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles effectively and safely. For example, we saw a recent review of how the practice managed medical emergencies, specifically suspected sepsis infections. The

Good

Are services effective?

(for example, treatment is effective)

practice had audited suspected cases and provided additional bespoke training and an educational session for all staff including reception staff on the red flag symptoms and the importance of timely medical intervention.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff told us they were encouraged and given opportunities to develop. We saw a variety of training certificates which demonstrated training had been completed.
- We noted a good skill mix among the doctors with a number having additional qualifications and special interests. For example, GPs at the practice had special interests in child and adolescent health, respiratory disease, rheumatology, diabetes and palliative care. One of the GPs we spoke with had a developing interest in autistic spectrum disorders and as part of this the practice held an autism themed coffee morning and was planning an autism information evening that will be run by the autistic society.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for nurse revalidation. For example, the health care assistant had completed all the requirements of the Care Certificate. The Care Certificate is designed for non-regulated workers and gives confidence that workers have the same induction - learning the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.
- The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice also operated an apprentice scheme, this involved an apprenticeship to gain a non-vocational qualification (NVQ) level two in customer service. The apprentice scheme had led to employment post scheme with the NHS including the local hospital.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received co-ordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Where appropriate the practice referred patients to the multidisciplinary assessment service (MuDAS). MuDAS provides GPs with access to specialist medical staff to support patients to stay at home and avoid being admitted to hospital. We saw the practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances and included Multi Agency Group (MAG) meetings where appropriate.

Helping patients to live healthier lives

The practice supported patients to live healthier lives through a consistent, targeted and proactive approach to health promotion and prevention of ill health.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The practice supported national priorities and initiatives to improve the population's health, for example, flu campaigns, healthy eating, stop smoking campaigns and tackling obesity. We saw a member of the patient participation group had commenced a free weight loss class, known as Tyrefighters. The practice provided a room and facilities (access to the health promotion room which contained a blood pressure monitor and weighing scales) for this group which met on alternate weeks during the practices extended hours clinic on Saturday mornings. The practice told us this group had been successful in achieving significant weight loss including some patients with long term conditions. The weight loss in some members of the group had resulted

in patients living a healthier life and a reduction in the number and quantities of medicines they were prescribed. The practice also told us the group was popular with older patients and male patients.

- In the last 12 months the practice had arranged a programme of awareness events, open forums and themed educational sessions to raise awareness of health conditions and promote good health in practice patients. For example, there had been a stroke awareness event in association with Bucks Stroke Support, various cancer coffee mornings in association with national cancer organisations, an autism awareness event and COPD/asthma event in association with Breathe Easy Aylesbury, supported by the British Lung Association. The practice and patients told us these events were well attended and helped to identify patients who required follow-up appointments.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. There was a health promotion room adjacent to the reception area which contained a blood pressure monitor, weighing scales and more recently a mobile tablet computer and headphones with a preloaded hearing test application.
- Information from Public Health England showed 96% of patients who were recorded as current smokers had been offered smoking cessation support and treatment. This was similar when compared with the CCG average (95%) and the national average (94%).
- There was a designated staff member who arranged and scheduled childhood immunisations and cancer screening recalls. This was evident as immunisation rates and patients attending screening programmes were higher when compared to the CCG and national averages.

Data from Public Health England indicated success in patients attending national screening programmes:

- 66% of patients at the practice (aged between 60-69) had been screened for bowel cancer in the last 30 months; this was higher when compared to the CCG average (60%) and national average (58%).
- 83% of female patients at the practice (aged between 50-70) had been screened for breast cancer in the last 36 months; this was higher when compared to the CCG average (77%) and the national average (73%).

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural and social needs.
- Written and verbal patient feedback commented practice staff gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 17 patient Care Quality Commission comment cards we received and the seven patients we spoke with were positive about the service experienced.

We also received positive feedback from external stakeholders which accessed GP services from the practice. For example, we spoke to all four care and nursing homes, they highlighted practice staff, specifically the GPs were good at listening and commented the GPs were respectful, supportive, compassionate and caring.

The written and verbal feedback we received did not align with the majority of the results in the July 2017 annual national GP patient survey. There had been 223 surveys sent out and 109 were returned. This represented approximately 1.3% of the practice population.

- 84% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average (90%) and the national average (89%).
- 79% of patients who responded said the GP gave them enough time; CCG average - 88%; national average - 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw; CCG average - 97%; national average - 95%.
- 83% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG average – 86%; national average - 86%.
- 92% of patients who responded said the nurse was good at listening to them; CCG average - 92%; national average - 91%.
- 95% of patients who responded said the nurse gave them enough time; CCG average - 92%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG average - 98%; national average - 97%.
- 93% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG average - 92%; national average - 91%.
- 82% of patients who responded said they found the receptionists at the practice helpful; CCG average - 85%; national average - 87%.

The practice was fully aware of these scores which demonstrated mixed levels of satisfaction. The practice had recorded patient satisfaction as a top priority and devised a 12 point action plan to improve. To further review patient satisfaction there was an improving practice questionnaire as a tool to obtain patient feedback including individual practitioner consultation skills feedback.

The improvement action plan was going to be discussed with the patient participation group in December 2017 with an intended launch of actions in January 2018.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and all staff had a comprehensive awareness of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given).

- Staff spoke clearly of the different steps involved to ensure patients who have a disability, impairment or sensory loss received information that they can easily read or understand and get support so they can communicate effectively. For example, staff described how patients were identified if they had information or

communication needs, this was then recorded and steps taken to make sure patients received information which they can access and understand and receive communication support if they need it.

- Patient literature was displayed throughout the practice, informing patients about the Accessible Information Standard and patient facing staff we spoke with told us how they encourage patients and their carers to inform staff of their communication needs.
- Patients registered at the practice were predominantly white British with little need for translation services. Staff told us that interpretation services were available for patients who did not have English as a first language and we saw a notice in the reception area informing patients this service was available.
- Email consultations were an option for patients who are profoundly deaf, there was a hearing loop and one of the practice GPs consulted using British Sign Language. This was specifically useful for a small cohort of profoundly deaf patients.
- A small number of patients from a local travelling community were registered with the practice. The practice recognised that some of these patients had literacy difficulties and verbal communication was used to support these patients.

Haddenham Medical Centre had achieved Gold, the highest award in the NHS 'Pride in Practice' award from the Lesbian, Gay, Bisexual and Transgender Foundation. This demonstrated the practice's commitment and dedication to ensuring a fully inclusive patient-centred caring service.

The practice identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 260 patients as carers, this equated to over 3% of the practice list.

- The practices provision of services to patients with caring responsibilities had recently been recognised by Carers Bucks (an independent charity to support unpaid, family carers in Buckinghamshire) and the practice was awarded an Investors in Carers GP Standard award. This was in recognition of the extra support they offer to unpaid carers who are registered at the practice. In order to receive this award, the practice exceeded the criteria set by Carers Bucks, which ranged from appointing a dedicated Carers Champion within the surgery, increasing numbers on the surgery's carers register, ensuring at least 50% of practice staff had attended a carer awareness training session, and demonstrating an understanding of the challenges faced by carers, for example, by offering flexible appointments where possible. We saw practice staff helped patients and their carers find further information and access community and advocacy services, for example through regular carers events held at the practice and through information on the practice website. We were told and we saw evidence of support specifically flexible appointments for young carers who care for a parent or another member of their family.
- Staff told us that if families had experienced bereavement, their usual GP contacted them. 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.

Similar to earlier results in the national GP patient survey; patients satisfaction to questions about their involvement in planning and making decisions about their care and treatment was lower when compared to local and national averages:

- 80% of patients who responded said the last GP they saw was good at explaining tests and treatments; CCG average - 88%; national average 86%.
- 76% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG average - 85%; national average - 82%.
- 84% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG average - 90%; national average - 90%.
- 80% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG average - 86%; national average - 85%.

Alongside the inhouse patient survey the practice collected NHS Friends and Family test information to review patient satiafaction. This was collected via text message which was sent out after a patient has attended an appointment, through the practice website and through the patient check in screen in the reception area.

Good

Are services caring?

These results aligned to the high levels of patient satisfaction we collected through written and verbal feedback. For example:

- Haddenham Medical Centre achieved a 91% satisfaction rate in the NHS Friends and Family Test in November 2017 (239 responses), 89% in October 2017 (200 responses) and 92% in September 2017 (334 responses).

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended opening hours were available on a Saturday morning in response to the patient survey findings to accommodate working patients.
- The practice improved services where possible in response to unmet needs.
- Haddenham Medical Centre was located in a purpose built medical centre, all the facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. We saw that the practice had installed replacement automated entrance doors that facilitated access for patients with a physical disability. Although the previous entrance doors were automated the practice had responded to patient comments that they were not always 'user friendly'.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs also provided home visits for those who had difficulties getting to the practice. The visiting GP commenced home visits earlier than traditional 'home visiting' with a view to early contact with district nurses, the community teams or other agencies that may be required to avoid hospital admission.
- A number of older patients and those living in rural communities relied on a local voluntary transport service to bring them to and from the practice. The practice operated a flexible appointment system to accommodate these patients and fit in with the times the voluntary transport service (a service which the practice actively supported) could get them to and from their appointments.
- Haddenham Medical Centre provided GP services to four local care and nursing homes for older people. There were designated GP points of contacts for the homes (approximately 88 patients). Contact details of the designated GPs were shared with the relevant staff, enabling continuity of care and quick access to the right staff at the practice. The designated GPs held regular visits to the homes and also provided appointments on an ad-hoc basis. We spoke with the representatives from each of the homes, they advised the practice was highly responsive. Regular meetings were held at the care and nursing homes with the focus of the meetings to support and educate to ensure the most appropriate care pathway was followed to ensure the best outcomes for patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Consultation times were flexible to meet each patient's specific needs.
- The practice facilitated and hosted a variety of educational sessions to support patients with long term conditions. For example, to reduce travel and increase access the practice hosted Diabetes structured education sessions. As a result, the number of patients newly diagnosed with diabetes, who had a record of being referred to a structured education programme was significantly higher when compared to the local clinical commissioning group (CCG) average and national average.
- There was an anti-coagulation clinic for patients receiving a medicine used in the prevention of blood clots; this could be provided at the practice or at the patient's home
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- A GP visited a local school to hold education sessions with the students and their families.
- Appointments including childhood immunisation appointments were available outside of school hours and the premises were suitable for children and babies.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice saw former patients who had been registered at the practice before their college/university studies to provide continuity of care.
- A travel clinic provided a full range of travel immunisations, malaria prevention and advice. Appointments for this clinic could be booked outside of traditional work/school hours, for example on a Saturday morning.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice website was well designed, clear and simple to use featuring regularly updated information. The website also allowed registered patients to book online appointments, request repeat prescriptions and view medical records.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability and increased flexibility for appointments for patients from the travelling community.
- The practice had identified that there were a number of military veterans in their patient population and had taken action to help ensure this group of patients received suitable support in line with the government's armed forces covenant. The practice encouraged these patients to identify themselves through signage at the practice, military veteran information packs, information on the practice website and via questions on the 'new patient' form. As a result of the increased awareness of the armed forces covenant, there had been a significant increase in the number of patients on the military veteran register.

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

- All staff had additional dementia training and all staff we spoke with had a good understanding of how to support patients with mental health needs and dementia. Following completion of the training we saw the practice had reviewed the accessibility of the practice. For example, the practice made colour changes to assist patients with dementia and reviewed practice signage with a view to making signs dementia friendly to improve navigation within the practice premises.
- Haddenham Medical Centre provided GP services to a local dementia care home. There was a designated GP point of contact for the home (approximately 29 patients). Contact details of the designated GPs were shared with the relevant staff, enabling continuity of care and quick access to the right staff at the practice. Similar to the feedback from the other three care and nursing homes, the representative from the dementia care home advised the practice was responsive to the residents ever changing medical needs.
- The practice signposted and encouraged the family, friends and carers of people with dementia to complete a three week e-learning course. This course was designed specfically to support people with dementia, or their carers, to 'stay connected and live well'.

Timely access to the service

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

- Patients had access to initial assessment, test results, diagnosis and treatment. During the inspection we saw GP and nurse appointments were still available on the day of the inspection and rest of the week.
- Waiting times, delays and cancellations were minimal and managed appropriately.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system and online appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mixed when compared to local and national averages.

- 61% of patients who responded were satisfied with the practice's opening hours compared with the CCG average of 72% and the national average of 76%.
- 78% of patients who responded said they could get through easily to the practice by phone; CCG average – 74%; national average - 71%.
- 88% of patients who responded said they were able to get an appointment to see or speak to someone the last time they tried; CCG average - 86%; national average - 84%.
- 87% of patients who responded said their last appointment was convenient; CCG average - 84%; national average - 81%.
- 65% of patients who responded described their experience of making an appointment as good; CCG average - 74%; national average - 73%.
- 55% of patients who responded said they don't normally have to wait too long to be seen; CCG average - 54%; national average - 58%.

The vast majority of patient feedback we received through discussions with patients and collected via the Care Quality Commission comment cards did not highlight access as a concern.

The practice was aware of the mixed levels of patient satisfaction collected via the GP patient survey. We saw the practice was active in reviewing the concerns and we were told about the improvements they had made to improve telephone access, appointment availability and overall patient satisfaction. For example, the appointments system had been reviewed and adjusted four times in recent years. The last change to the system had taken place in 2014 and continued to be subject to evaluation. The practice and the patient participation group were working together to embed changes and continue to improve patient satisfaction.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We reviewed the practice complaint log and found that they were satisfactorily handled in a timely way. With the exception of one complaint which required additional forms of consent, all complaints had been responded to in full within 20 working days.
- Each year the practice drafted an annual complaints report. The practice told us the report had many functions, for example, a tool to analyse and identify trends, reviewed learning points and ensured any changes to procedure established (at the time of the original complaint) were still appropriate, and embedded within routine operations.

Through discussions with staff and a review of the annual complaints report we saw the practice learned lessons from individual concerns and complaints and also from analysis of trends. For example, several complaints referred to the inability to speak with a GP on the day of request. The practice, in conjunction with the patient participation group reviewed the appointment system and agreed the provision of a duty doctor triage system to enable patients ability to speak to a GP on the day if required.

Are services well-led?

Outstanding ☆

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

Our findings

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

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- All staff were encouraged to participate in roles outside the practice with a view to bring back examples of best practice within primary care and to increase their knowledge base about issues and priorities relating to the quality and future of local and national services. The practice understood the challenges within the local area and were addressing them. For example, a GP and the practice manager worked collaboratively with the clinical commissioning group and helped develop the winter resilience paramedic visiting service.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice leadership was committed to meeting the needs of its population. This was evidenced through themed and targeted services, clinical audits and health promotion. This included a range of initiatives to meet the needs of specific groups – for example people with dementia, older people facing isolation and transport difficulties, military veterans, carers, Deaf people, travellers and the LGBT community.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. We saw the practice celebrated successes within the practice, for example the practice nominated the reception manager for an award at The National Primary Care Awards.
- Haddenham Medical Centre was a GP teaching and training practice and also ran an apprentice scheme. We received extensive written feedback from one of the trainees who spoke of the quality of leadership and support received at the practice.

Vision and strategy

The practice had a vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting plans to achieve priorities.
- Strategies and plans were aligned with plans in the wider health economy and there was a demonstrated commitment to a system wide collaboration and leadership. For example hosting numerous health themed events for the whole community and not just their own registered patients.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. For example, the promotion of healthier lives through a consistent, targeted and proactive approach to health promotion and prevention of ill health.
- The practice planned its services to meet the needs of the practice population. For example, the anticoagulation clinic, the whole practice endeavour to support patients with caring responsibilities and the flexibility for the travelling community.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients. There was a whole team commitment to improve the quality of patient care and the experiences of patients
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to safety incidents, complaints and clinical audit findings. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. The staff meeting structure as well as the inclusive culture of the practice supported this.

Are services well-led?

Outstanding ☆

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

- There were processes for providing all staff with the development they need. This included appraisal, career development conversations and the successful apprenticeship scheme. All staff received regular annual appraisals and were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including the nurses and health care assistants, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. The health care assistant highly praised the clinical supervision from the lead nurse in preparation for career progression and nurse training.
- There was a strong emphasis on the safety and well-being of all staff. This was evident in discussions with the practice manager and staff. The practice recognised that staff retention was integral to delivering a high quality service and encouraged staff development in line with the needs of the individual, as well as the practice, and worked hard to ensure high staff satisfaction
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. Staff we spoke to told us they felt well supported and knew who to go to in the practice with any concerns.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. For example, the practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. For example the practice's proactivity in improving their antibiotic prescribing to ensure good antimicrobial stewardship. Furthermore, through the development of a comprehensive sepsis toolkit.
- The practice had processes to manage current and future performance. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The majority of the QOF data showed the practice was performing above local and national averages. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. The practice was aware of some areas of low patient feedback and was actively trying to increase patient satisfaction the items of patient feedback.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. This included formal meetings and informal communal, timetabled staff tea breaks for all staff to share information.

Are services well-led?

Outstanding ☆

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

- The practice used up to date information technology systems to monitor and improve the quality of care. During the inspection, the practice was migrating management and information system, to a system designed specifically for GP practices, the aim of this migration was to gain greater control of the practice and strengthen collaborative working.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. This was collaborated through our discussions with patients, the patient participation group and the external stakeholders that accessed GP services from the practice.
- A patient newsletter had recently been launched as one of the practices tools to strengthen engagement with patients.
- There was an active patient participation group (PPG); we spoke with members of the PPG following the inspection who told us that the practice was receptive to most of their suggestions. The PPG met every two months and were always attended by the practice manager and senior GP partner. We also saw additional meetings with the PPG Chair and Vice-Chair when specific issues arose. The PPG had conducted various patient surveys, one of which specifically reviewed inappropriate usage of the practice carpark following a concern raised by a patient. A member of the PPG worked in conjunction with the practice with reference to health promotion, specifically weight loss and exercise. The practice and PPG had reviewed its' results from the national GP survey to see the areas that needed addressing. The practice was actively encouraging patients and the patient participation group to be involved in shaping the service delivered at the practice.
- Members of staff attended local events where they updated the community on the service offered and gained an insight into local issues affecting delivery of health and social care. For example, the Haddenham Community Christmas Tree Festival and the Haddenham Scarecrow Festival. We also heard the practice provided rabies vaccinations to staff and volunteers at the local animal sanctuary and had supported the community following concerns regarding bird flu.

Continuous improvement and innovation

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

- Central to the culture of the practice was one of learning and development. The practice was a GP teaching and training practice, supported medical students, nursing students and apprentices. We heard that the GP trainers supported GPs in training that required extra help in addition to the day to day training of prospective GPs allocated to the practice. The practice had been approved for training for a number of years and two of the GPs held additional medical teaching qualifications.
- The staff we spoke with all told us they received annual appraisal. They told us this included reviewing their achievements, looking at objectives for the year ahead and identifying their training needs.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice was active and worked collaboratively with other local practices, the clinical commissioning group and the local GP Federation. (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).