The Manor Street Surgery

Quality Report

Manor Street
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Date of inspection visit: 23 March 2015
Date of publication: 04/06/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Manor Street Surgery on 23 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families with young children, working age people, those whose circumstances make them vulnerable and those patients suffering with mental health problems.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

We saw one area of outstanding practice:

- The practice demonstrated genuine commitment to learning, sharing experiences and ways to improve patient outcomes by holding a 'Journal Club' and regular meetings. GPs and nurses met monthly and focussed on a specific topic which one member of the team would have researched and shared information and best practice with the team that provided an opportunity for discussion and learning. Guest speakers were also invited to update the team on the latest service developments available for patients.

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

Importantly the provider should:

- Ensure that all staff complete the training in adult safeguarding, infection control and fire training as planned.
- Carry out a new infection control audit as agreed when training is completed to include the risk assessment and mitigation of risk due to absence of elbow taps in clinical rooms.
- Carry out a formal risk assessment for all staff who act as a chaperone if they do not have a Disclosure and Barring Service (DBS) check.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that 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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that 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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders took place.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

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 and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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 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.

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. It had carried out annual health checks for people with a learning disability patients had received a follow-up. It offered longer appointments for people with a learning disability and they were seen promptly.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards and all were positive about the service experienced with the exception of two who reported some dissatisfaction with the attitude of specific reception staff . Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We spoke with five patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We spoke with the chair of the patient participation group (PPG) who told us that the practice had always worked well with the group and was responsive to the suggestions which were conveyed via the PPG. They provided examples of suggestions and actions that had been implemented that had improved services for patients, such as the practice newsletter.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure that all staff complete the training in adult safeguarding, infection control and fire training as planned.

The practice should carry out an infection control audit as agreed when training is completed to include the assessment and mitigation of risk in the absence of elbow taps in clinical rooms.

The practice should carry out a formal risk assessment for all staff who act as a chaperone if they do not have a Disclosure and Barring Service (DBS) check.

Outstanding practice

The practice demonstrated genuine commitment to learning, sharing experiences and ways to improve patient outcomes by holding a 'Journal Club'. GPs and nurses met monthly and focussed on a specific topic which one member of the team would have researched and would share information with the team and provided an opportunity for discussion and learning. Guest speakers were also invited to update the team on current best practice and service developments.

The Manor Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP and another CQC inspector.

Background to The Manor Street Surgery

The Manor Street Surgery provides primary medical services under a general medical services (GMS) contract to a population of approximately 9,700 patients who live in the Berkhamsted and surrounding areas. The practice has five GP partners two female and three male and employs a salaried GP and one regular locum GP, a nurse practitioner, two practice nurses, a health care assistant and practice manager who are supported by several reception and administrative staff. The practice is a training practice which provides a learning environment, support and guidance to newly qualified doctors who wish to become GPs. The practice population does not encounter high levels of deprivation, although there are small pockets of deprivation in some areas. When the practice is closed services are provided by Hertfordshire Urgent Care or via the NHS 111 service.

Why we carried out this inspection

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

We carried out 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 the surgery was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to

Detailed findings

share what they knew. We carried out an announced visit on 23 March 2015. During our inspection we spoke with a range of staff including GPs, nurses, the practice manager, reception and administration staff and spoke with patients who used the service. We observed how staff dealt with patients when they attended the practice and talked with family members. We also spoke with the chair of the patient participation group (PPG) to gain their views about how the practice engaged with them.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these, although we noted that there were only two reported in the last 12 months. We saw that significant events were not a standing agenda item but the practice manager told us they were discussed as and when they occurred. The practice manager and the GPs told us that they all met daily during coffee time and had opportunities to discuss any issues informally as well. Following discussions with staff and minutes from meetings it was evident that there was good communication within the practice and any safety issues were addressed. There was evidence that the practice had learned from significant events and complaints and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. 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. The practice reviewed significant events and complaints annually in April to identify any possible themes.

National patient safety alerts were disseminated by the practice manager to a specific person in the practice who would circulate to the appropriate staff. Staff we spoke with confirmed that alerts were circulated to the relevant people.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. They informed us that all clinical staff had received relevant role specific training on safeguarding children and we saw that this was recorded on the practice training spreadsheet. Administrative staff had also received training in child safeguarding, but not safeguarding vulnerable adults. However, they informed us they had received an overview of safeguarding at a team meeting in the past. We did not see any evidence of training on safeguarding vulnerable adults. We spoke with staff who knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible on the noticeboards in consulting and treatment rooms. Following our inspection the new practice manager provided evidence to confirm that the practice had addressed this and training for staff had been sought and was scheduled to take place in May 2015.

The practice had appointed a dedicated GP as a lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. The practice told us that any A&E reports for children under five seen with an injury are passed to the safeguarding lead to ensure that no trends were evident.

There was a system to highlight vulnerable patients on the practice's electronic records. Staff told us there was a management box within the record which contained information to make staff aware of any relevant issues when patients attended appointments; for example

children subject to child protection plans. Safeguarding issues were discussed at multidisciplinary meetings and the safeguarding lead met with the health visitor monthly to discuss children at risk of harm.

There was a chaperone policy, which was visible at the reception desk and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Reception staff informed us that they were pro-active and informed patients of the chaperone policy as required. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. They had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Reception staff carrying out this role had not received a Disclosure and Barring Check (DBS) but the practice informed us these staff members would not be left alone with patients.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff were able to describe what they would do in the event of a failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw that the practice had a prescribing lead GP who attended the quarterly prescribing meetings. Any changes or actions were reported back to the GP and prescribing nurses as required. Minutes of partners meeting confirmed that prescribing issues were discussed as necessary.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

A member of the nursing staff was qualified as an independent prescriber. Another nurse was completing the training. They received regular supervision and support in their role.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. There was an alert on the clinical system to ensure that appropriate action was taken based on the results prior to prescribing.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. Staff described the checks they would make to ensure the patient's repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance. We saw records that showed these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and the practice manager told us they carried out checks to ensure the required standard was met. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice manager was the lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We did not see evidence that all staff had received induction training about infection control specific to their role or subsequent infection control training. However, we saw evidence that the practice manager had circulated the latest infection control guidance and supporting videos and instructed the staff to become familiar with them. We saw evidence that an audit had been carried out in March 2014 with identified areas for improvement but no actions were documented to rectify these issues. However, through our observations it was clear that some of the recommended actions had taken place. Following our inspection the new practice manager confirmed that they had taken over the role as infection control lead and had sourced training for all staff which was

to take place in June 2015 and they had also included this in a new induction programme that they had introduced. They also confirmed that a new audit would take place following this training. We will look at this at our next inspection of this practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and we saw staff had access to blood spill kits.

Notices about hand hygiene techniques were displayed in the treatment rooms but we did not see any in the staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw that hot water was supplied via wall mounted electric hot water heaters. Staff were required to turn a dial to gain hot water instead of using elbow taps. We noted this was an infection control risk and had been identified on the infection control audit but no action had been taken to reduce this risk.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The policy contained a risk assessment which indicated that there was a low risk of legionella contamination as the practice had a closed water system.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly by an external company and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed labels indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

We looked at three staff records and noted that qualifications had been checked and photographic identify had been checked but the practice did not copy and maintain one on the staff file. We noted that it was not the practice policy to obtain references for all staff as they did not consider this to the best way to determine a person's suitability for the role. The practice manager reported that they did obtain telephone references when they did not know the applicant and acknowledged that this should be part of the recruitment procedure in the future.

We saw that qualifications and registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) had been checked. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, following our inspection the new practice manager informed us that they had reviewed the recruitment procedure and implemented a new system which included two references and that all staff records now been updated and contained photographic identification.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us that only one nurse or member of the administrative team could be on leave at the same time.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager informed us that staffing levels were reviewed at regular intervals. The practice used one permanent locum GP and informed us they did not require the use of other locum GPs or agency staff which indicated that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The

practice also had a health and safety policy. Health and safety information was displayed for staff to see on the staff noticeboard and there was an identified health and safety representative.

Whilst there was no collective risk log, but we saw that risks had been identified and mitigated individually. Most risks had been assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. A member of staff described a medical emergency concerning a patient who had collapsed outside the practice. They informed us that appropriate action had been taken and staff present at the time discussed the event to debrief and identify any learning.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. We saw records that showed the checks were carried out each month. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff practised regular fire drills. The practice informed us that some staff had received fire training but we did not see a record of which staff this included or any certificates to evidence that the training had been received. Following our inspection the new practice manager confirmed they had sourced comprehensive fire training and this was due to be undertaken by staff in May 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with GPs and nurses at the practice who were able to describe the rationale for their approach to treatment for patients. They demonstrated a commitment to use of current best practice and guidelines such as those from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Following discussions with GPs and reviewing minutes from clinical meeting it was clear that new guidelines had been disseminated and discussed and changes in practice implemented where necessary. These discussions also highlighted that thorough assessments of patients' needs took place and were reviewed in line with best practice guidelines.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Staff reported they found the practice 'journal club' a particularly useful way of learning about new developments in practise and useful to share experiences to help improve patient care. This is where a member of clinical staff investigated a specific topic and reported to the group current best practice. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of different aspects of care. We saw a programme of topics for presentation to the members of the clinical team, including, for example, osteoporosis, results of clinical audit and abnormal blood tests.

We saw that the practice engaged with the local CCG and received data regarding their performance for areas such as antibiotic prescribing which they reviewed and actioned when necessary. We saw audits that showed the practice had developed a care pathway for patients who had been identified as having high blood pressure following the use of 24 hour blood pressure monitoring. They had also completed a review of case notes for patients with heart problems who were at high risk of stroke to ensure they were on the correct medication to protect them. The practice used computerised tools to identify patients with complex conditions who may be at risk of admission to hospital. These patients had care plans, which were reviewed every three months or sooner if patients had been admitted to hospital.

Discussions with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. We noted that discrimination was avoided when making care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit, although they had not been revisited to demonstrate that the changed had been sustained after a period of time. We saw that results of the audit for atrial fibrillation was on the 'journal club' agenda to be shared. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had a higher than the CCG and

Good

Are services effective?

(for example, treatment is effective)

national average in the overall QOF outcomes and met all the minimum standards for QOF in almost all areas such as diabetes, asthma and chronic obstructive pulmonary disease.

The practice was a teaching practice and as such the team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff and share learning and outcomes of good practice or when things went wrong. The staff we spoke with confirmed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The clinical system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw evidence of multi-disciplinary meetings and appropriate actions as a result.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one GP having an additional diploma in sexual and reproductive medicine and one nurse having training in the insertion of contraceptive implants as well as additional qualifications such as nurse prescribing and diploma in asthma and chronic obstructive pulmonary disease (COPD).

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff files showed that staff undertook annual appraisals that identified learning needs from which action plans were documented, although they had not been completed for this year due to a new practice manager taking over. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, one nurse told us that the practice was encouraging them to undertake the nurse practitioner training. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and wound care management. The practice nurse told us they had achieved a diploma in asthma and COPD and had recently completed a non-medical prescribing course.

We looked at staff files and noted an occasion where the practice manager had identified poor performance and had taken appropriate action to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from

communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. Staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned to provide the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. The practice manager told us that the safeguarding lead met with the health visitor monthly to discuss any children on the at risk register.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice told us that the A&E reports for any child under five seen with an injury were passed to the safeguarding lead for assessment. The practice had also signed up to the electronic Summary Care Record which provided faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. Staff were fully trained on the system and told us they attended a user group to share experiences, issues and new facilities that developed within the system. They commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice manager told us that one of the GPs audited 10% of new patient summaries to verify accuracy of the summarising.

Consent to care and treatment

Clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. The practice provided services to a local learning disability hostel and demonstrated an understanding of the issues that they may encounter regarding capacity and consent. The practice undertook health reviews for patients who lacked capacity and demonstrated appropriately how they dealt with this. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice had met with the local NHS England team and the CCG to discuss the implications and share information about the needs of the practice population. Information about the health and social care needs of the local area was obtained centrally and available for service providers. This information was used to help focus health promotion activity.

The practice offered a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Discussions with staff highlighted a commitment to use their contact with patients to help maintain or improve mental, physical health and wellbeing at every consultation. For example, chlamydia screening was offered to patients aged 15 to 25 years and the practice offered a specialist smoking cessation advice to smokers via a clinic session.

NHS Health Checks were offered to patients aged 40 to 75 years and any anomalies were referred to the GP in a timely way to determine any further investigations which may have been required. We saw records that showed the practice had carried out 473 health checks for the year which was 11% of the patients who were eligible.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and these patients were offered an annual physical health check.

The practice's performance for cervical smear uptake was 98%, which was higher than others in the CCG area. The practice had a system to deal with patients who did not attend which was in line with national guidance. A family planning clinic was held once a week and appointments could be made outside of the clinic time for those patients who could not attend at that time.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. They held a child health clinic one day a week where one specific GP carried out child health checks and the nurse gave immunisations. Last year's performance for all immunisations was 99.2% which was above the 96.6% average for the CCG.

The practice had a robust system of calling patients with long term conditions for review and we saw that they achieved a high level of patients who had received an annual review. All patients over 75 years had a named GP who oversaw their care and all had a dedicated telephone number to contact the surgery.

The community mental health team attended the practice one afternoon each week which allowed the practice to refer patients with mental health issues for support and therapy close to their home.

We saw a variety of health promotion literature and information available in the waiting areas such as 'keeping warm in winter', Citizens Advice Bureau, alcohol support groups, information on the shingles vaccine and children's' centres.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 95% of patients who responded described their experience of the practice as good. This was above the CCG average of 87%. Ninety-four percent of patients also rated the practice as being good at listening and 84% and 92% reported being treated with care and concern by the GPs and nurses respectively.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We observed that potentially private conversations held between administrative staff and patients at the reception desk could be overheard in the waiting area due to the open nature of the reception. The practice switchboard was located away from the reception desk, but administrative staff at the reception desk also took telephone calls from patients when the other staff were already taking calls. However, staff we spoke with commented that they would not answer the telephone if a patient was standing at the reception desk in order to reduce the risk of breaching confidentiality and we noted that this was the case during our inspection.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. One patient informed us their sick child was involved in the consultation and they were able to get an urgent appointment without difficulty. Patient feedback on the comment cards we received was also positive and aligned with these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at giving them enough time. Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of respondents who completed the national survey reported that the GPs were good at explaining test and treatments. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. For example, Macmillan Cancer Support and Age Concern. The practice's computer system alerted GPs if a patient was also a carer. We saw

Good

Are services caring?

information in the waiting room available for carers to ensure they understood the various avenues of support available to them. This included a local Carers in Hertfordshire website and helpline number, and Carers UK information.

The practice told us that they reviewed the deaths of all patients weekly at the GPs meeting and contact was made with the family by the appropriate GP. We saw evidence of minutes from the meetings which confirmed this happens consistently. The GP would follow up with a visit to the family if appropriate to meet the family's needs or provide advice on how to find a support service. Reception staff informed us an alert was put on the family members' record and that they were mindful of their recent bereavement when they visited the practice.

We saw that the practice had asked the PPG to support them in work to help identify more people who were carers and raise awareness. The practice had an identified member of staff in the practice who was the 'Carers Champion'. They had worked with the PPG and identified eight more carers so that they could direct them to appropriate support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice told us that they engaged with the Clinical Commissioning Group (CCG) and one of the GPs attended regular meetings with the CCG to discuss local needs and service improvements that needed to be prioritised which were fed back to the rest of the practice. We saw that the practice had identified the needs of its specific population. For example, they have patients registered from a local learning disability hostel and put measures in place to ensure these patients were seen promptly when they attended the surgery to prevent them becoming distressed.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We saw minutes of meetings where access to the surgery had been discussed and agreements that the practice would increase their extended hours appointments in response to feedback from the PPG who reported that the practice may not have been fully meeting the needs of the patients who worked, specifically the a significant number who commuted to London daily.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, those with learning disabilities and those with mental health problems.

The practice had access to translation services for those patients whose first language was not English. There was no evidence of equality and diversity training although the practice was about to undergo a change of practice manager and the new manager who was present during our inspection told us that they intended to ensure this was accessible via e-learning shortly. Staff we spoke demonstrated a non-judgemental attitude and were helpful to all patients and we saw that they treated patients equitably when dealing with them at reception and on the telephone.

The premises and services had been adapted to meet the needs of patient with disabilities, there was disabled access with ramps and electronic doors. We also saw there was a disabled toilet with baby changing facilities.

Although the practice consisted of a ground and first floor, patients were only seen on the ground floor level. The waiting areas was large enough to enable access for wheelchairs, other mobility aids and pushchairs. This made movement around the practice easier and helped to maintain patients' independence.

Access to the service

Appointments were available from 7am to 8pm on Mondays and 8am to 6.30pm Tuesday to Fridays. This included their extended hours appointments. They also opened on the second Saturday of the month from 8am to 12midday for both GP and nurse appointments. These were particularly useful for those patients who worked and for families with children attending school during the week. In addition there are two telephone surgeries held a week. Whilst the practice was meeting its contractual requirements for extended hours, they agreed to a three month trial of additional extended hours in response to feedback from the PPG that the needs of patients who worked may not be being met. All of this information was clearly advertised for patients on the website and was also detailed in the PPG plan following the patient survey.

Access to the community mental health team (CMHT) was also available and the CMHT cognitive behavioural therapy staff one afternoon per week to provide care near to patients' homes for those patients with mental health issues.

The practice demonstrated a commitment to ensuring good access and monitored patient access to appointments by assessing availability of the third available appointment daily for both nurses and GPs. We saw that there was generally good accessibility.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There

Good

Are services responsive to people's needs?

(for example, to feedback?)

were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, their call would be diverted to Hertfordshire Urgent Care who would deal with their problem. Information on the out-of-hours service was provided to patients in the practice leaflet and on the website.

Patients were generally satisfied with the appointments system and appointments could be made by telephone, online or by attending the surgery. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Patients we spoke with told us if they were in urgent need of treatment they had been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a 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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the practice leaflet in the surgery and also on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint although none of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 14 complaints received in the last 12 months and found that these had been dealt with in a timely way and managed appropriately with openness and transparency. We noted from minutes of meetings that the practice manager had shared specific complaints with the staff and organised learning scenarios to involve staff in identifying how things could be handled differently.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 which was personal, efficient and readily accessible and discussions with the GPs and staff demonstrated they had a commitment to this vision. These values were clearly displayed in the practice leaflet and on the website.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of staff meetings and saw that agenda items had included discussions regarding issues that could affect patients and how things could be improved.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a selection of these policies and saw that they were in date and appropriate. The practice manager told us that they would notify all staff of any change in the procedures and instruct them to read the documents. We saw evidence of an email to staff instructing them of the need to familiarise themselves with the latest infection control guidance. If there were no specific changes then policies were updated every two years.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a GP lead for safeguarding, prescribing, dermatology and a specific lead for governance. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed clinical performance was above the national and CCG average. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had completed a variety of audits which it used to monitor quality and systems to identify where action should be taken. For example, regarding home blood pressure monitoring and an audit concerning heart medication. We saw that the practice discussed the outcomes of audit at a specific clinical meeting they had developed called 'The Journal Club'. This was where GPs and nurse met monthly and focussed on a specific topic which one member of the team would have researched and would share information with the team and provided an opportunity for discussion and learning.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us individual risk assessments but they did not keep a collective log. We saw that risks were identified and regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held weekly clinical meetings and monthly staff meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. Staff reported that communication within the practice was good and they felt well informed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly for administrative staff , nurses and doctors and additional weekly meetings for GPs. Staff we spoke with told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. They also reported feeling supported in their role by GPs and the practice manager.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. We were shown that all policies were available electronically for all staff to access. Staff we spoke with knew where to find these policies if required. We noted that there was a staff noticeboard which contained information regarding the Employee Assistance helpline.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patients' surveys, comments and suggestions and from complaints. We looked at the results of the annual patient

Are services well-led?

Good

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

survey and changes and improvements made as a result were described by the practice manager and confirmed by discussions with the chair of the patient participation group (PPG) and information on the website.

The practice had an active PPG who worked with them and were continually exploring ways of increasing representation of younger patients. The chair of the PPG told us that they had carried out several surveys to gain the views of patients and had analysed these and presented suggestions to the practice. We saw that the practice had been responsive to these suggestions and had agreed to changes. For example, the feedback from patients suggested that the current extended hours available were not meeting the needs of the working population. The practice agreed to a three month trial of additional extended hours to provide more availability to those patients who worked or could not attend during the daytime. Analysis of patient comments suggested that communication from the practice could be better. As a result, the PPG, in collaboration with the practice, produce a quarterly newsletter, agreed and funded by the practice which was available in the surgery and on the website. The practice had also introduced an improved website as a result of patient feedback. We saw analysis of the patient survey and that the results and actions agreed were available on the practice website.

We noted that the current long-term manager was retiring and a new manager had been appointed with a hand over period. The PPG chair told us that the practice had invited them to meet the new practice manager to introduce them and continue good communication.