The Colne Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Colne Medical Practice on 18 March 2015. Overall the practice is rated as good.

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

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.
- Risks to patients were assessed and managed, with the exception of those relating to infection control and recruitment checks.
- 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.

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

Importantly the provider should:

Summary of findings

- Ensure the recruitment policy includes all necessary pre-employment checks for all staff to include photographic identify, disclosure and barring service check and a reference check.
- Update policies specifically infection control, to ensure they accurately reflect the actions to be taken.
- The practice should ensure that infection control training is completed and an infection control audit completed following this.
- Ensure appraisal takes place for the nursing staff.
- Repair or remove the damaged seating and remove plugs from clinical areas.
- Consider regular meetings with administration and reception staff.

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 staff although the nurses appraisals were still outstanding. 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 highly and that 99% of patients had trust and confidence in their GPs. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were offered kind and compassionate care. We found many positive examples through patients' comments to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were positive and aligned with our findings.

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.

Summary of findings

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. 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 was shared with staff.

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, although some required updating. They held regular governance meetings and 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 practice had engaged with patients via a virtual patient participation group (PPG) and had sought and acted on surveys and comments. Staff had received inductions, regular performance reviews and attended staff meetings, with the exception of reception and administrative staff who reported these did not take place regularly.

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. 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. The practice gave 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.

Summary of findings

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. Longer appointments for people with a learning disability could be arranged if necessary.

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). People experiencing poor mental health had received 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 including MIND. 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

We spoke with six patients during our inspection who spoke highly of the care received from both GPs and nurses at the practice. They told us that they offered a good service and that they were always able to get an appointment and be seen in an emergency.

Comment cards patients left for us at the surgery were all very positive and reported very good levels of care and described kind, caring, professional, staff and excellent care clinical care from doctors and nurses. They reported feeling safe, well supported and listened to and expressed appreciation of the service.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure the recruitment policy includes all necessary pre-employment checks for all staff to include photographic identify, disclosure and barring service check and a reference check.

The practice should update policies, specifically infection control to ensure they accurately reflect the actions to be taken.

The practice should ensure that infection control training is completed and carry out an infection control audit.

The practice should ensure appraisals are carried out for the nursing staff.

The practice should repair or remove the damaged seating and remove plugs from all sinks.

The practice should consider regular meetings with administration and reception staff.

The Colne Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Colne Practice

The Colne Practice provides primary medical services to a population of approximately 10,200 patients in the Rickmansworth and surrounding areas under a general medical services (GMS) contract. Services are delivered by a team of staff consisting of nine GP partners, two male and seven female, four practice nurses, one health care assistant, a phlebotomist, a practice manager and assistant practice manager and are supported by 12 administrative and reception staff.

The practice population consists of a higher than average number of patients over 75 and slightly higher than average number of patients between 35 and 54 years of age. The deprivation score for the area is 7 which indicates a lower level of deprivation.

Patient services are arranged over two main floors, which were a lower ground and ground floor. Administrative staff were based on the ground, first and second floors with the third floor in use as a staff meeting area and learning environment.

Primary medical services are provided by the NHS 111 service during out of hours when the surgery closed.

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

Detailed findings

- 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 share what they knew. We carried out an announced visit on 18 March 2015. During our inspection we spoke with a range of staff including the practice manager, GPs, nursing and administrative staff. We spoke with patients who used the service and observed how staff dealt with patients and relatives who attended the practice.

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. For example, we saw evidence of an event where information had been disclosed to the incorrect person and that this had been reported, discussed and measures put in place to prevent a recurrence.

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. We saw that significant events were discussed at practice meeting and when they occurred. We saw evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue or concern and they felt they could do so when necessary.

Staff completed incident forms and sent these to the practice manager for analysis and were discussed at practice meetings and relevant actions implemented. The practice manager showed us the system used to manage and monitor incidents. We tracked a selection of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. 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.

National patient safety alerts were disseminated by a specific member of staff who circulated to the GPs or nurses where appropriate. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. The practice manager gave an example of when they had been advised to prescribe a specific generic medication and had alerted all staff. We saw evidence of this via an email. They also told us any relevant alerts were discussed at practice meetings. We saw that the practice manager also circulated weekly emails summarising any alerts or changes in the practice as a result of alerts or events.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of the nursing and administrative staff about their most recent training and they confirmed they had received training but now required an update. Staff 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.

The practice had appointed a dedicated GP as the 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 these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice manager told us that one GP met with the health visitor monthly to discuss any concerns and the health visitor also had open access to the GPs. The practice made use of a system call 'Community Navigator' which signposted vulnerable patients to appropriate organisations for additional support.

There was a chaperone policy, which was available to staff and there were notices in the practice advertising that this was available. (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). 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. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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 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 followed the policy.

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.

The nurses and the health care assistant had been trained in administration of vaccines and carried out this task using directions that had been produced in line with legal requirements and national guidance.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. We saw that bi-monthly checks were carried out and blood tests arranged to ensure these medicines were appropriately managed and action was taken based on the results. The practice manager told us that the repeat prescribing policy was being reviewed and updated along with all policies and will now be updated yearly.

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 and 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. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control and comment cards also confirmed this view. We saw the practice had an external cleaning contractor and there were cleaning schedules in place and cleaning records were kept and signed to confirm the cleaning had been completed.

The practice had a lead nurse responsible for infection control; however, we did not see evidence of recent infection control training for the lead person or any of the staff. Some staff we spoke with told us they had undertaken infection control training in other employment. There was no evidence to show that staff had received induction training in infection control specific to their role, however, the practice told us that they were now reviewing all infection control to include training and appropriate updates.

Following our inspection, the practice manager contacted us to confirm that training had been sourced and arranged for all staff which would be completed by 30 April 2015. They told us this had been discussed in the nurse team meeting and there was now a plan in place to highlight any subsequent actions required following the training. The nurses had fortnightly meetings with a nominated GP and it had been agreed by the practice that they would report back to the partners any risks or actions required. They had also arranged a meeting with the cleaning company management to discuss the cleaning schedules.

We saw no evidence of an infection control audit but the practice appeared clean and tidy. The practice manager told us that the infection control lead had only returned to work two weeks prior to our inspection and would be resuming their role and reviewing procedures. We noted that some chairs in the waiting area that had tears to the coverings which could pose a contamination risk.

We saw there was an infection control policy for staff to refer to, which enabled them to plan and implement measures to control infection but noted that this required updating. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms although there were some clinical areas where elbow taps were not available and plugs were still located at the sink but did not appear to be in use .

The practice had had a legionella risk assessment carried out in August 2013 by a specific contractor but there was no evidence of any action plan. Legionella (a bacterium that

can grow in contaminated water and can be potentially fatal). However, the practice told us that they had addressed the relevant risk areas specifically the running of taps and clearing of lime scale which was carried out by the cleaning contractors. They told us they had also arranged Legionella training for relevant staff to be completed by the end of April 2015.

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 and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment had been tested in 2012 and the practice was arranging further testing for this year. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices.

Staffing and recruitment

We looked at staff records and found that appropriate recruitment checks had been undertaken prior to employment with the exception of the health care assistant. The health care assistant had worked for the practice for over seven years as a receptionist and had transferred role, therefore the practice had not sought a criminal records check through the Disclosure and Barring Service (DBS). However, we saw that this had been applied for and an application had been submitted to renew all DBS checks. We saw proof of identification, references, qualifications, registration with the appropriate professional body and DBS checks. The practice had a recruitment policy but it did not reflect the procedure followed as the policy did not include the need to obtain a reference, a DBS check and photographic identification, although the practice had done this.

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. The practice manager told us that several staff job shared and were able to cover each other during sickness or annual leave.

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.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

We saw that risks were identified individually such as fire and significant event. Each risk was assessed and 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. We saw that there was a fire warden for each floor of the building and fire evacuation training had been carried out the previous week.

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.

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 and anaphylaxis. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. 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 manager told us

Good

Are services safe?

they also kept a copy of the business continuity plan at home in case they required contact details of services urgently. The practice had carried out a fire risk assessment that included actions required to maintain fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Following discussion with the GPs and nursing staff we found that they could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they allocated specific GPs to lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. Clinical staff we spoke with told us they were able to discuss issues and concerns about care with colleagues and met daily in the staff room to facilitate this. GPs, nurse and trainees told us this supported all staff to continually review and discuss new best practice guidelines for the management of patients conditions.

We saw data from the local CCG of the practice's performance for antibiotic prescribing, which had been higher than similar practices but was improving. One GP was allocated to attend the meetings with the CCG who reported back to the rest of the practice the progress on their key performance indicators. The practice were able to identify patients with complex needs who had multidisciplinary care plans documented in their case notes . The practice had a system to identify patients who had recently been discharged from hospital who needed to be reviewed. The practice told us that they reviewed their referral rates to secondary and other community care services for all conditions and were in line with the rest of the CCG area.

We saw no evidence of discrimination when making care and treatment decisions. Interviews 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.

Management, monitoring and improving outcomes for people

We saw that staff had specific 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 and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us several clinical audits that had been undertaken in the last two years. We saw evidence of two completed audit cycles with appropriate changes to clinical practice. For example, one audit resulted in a full review and changes to the practice's approach to patients at risk of foot problems as a result of their diabetes. There were also numerous single audit cycles which had been undertaken and changes made as a result, for example an audit of dermatology referrals.

The practice told us clinical audits were often linked to medicines management information, safety alerts 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). We also saw an example where the practice manager had highlighted incorrect coding for procedures which had identified a need to audit patients having received contraceptive devices.

The practice also used the information collected for the QOF and to monitor outcomes for patients. The practice had reached a high level of achievement in most areas, with the exception of diabetes and hypertension.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and

Good

Are services effective?

(for example, treatment is effective)

areas where this could be improved. For example, they had checked the histology results of minor surgery to determine any anomalies. 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 accordance 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 IT 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. 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. They had a palliative care register and held monthly multidisciplinary meetings which included the health visitor, palliative care nurse, district nurse and GPs. Care and support needs of patients and their families were discussed at this time and appropriate changes in care actioned.

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 with other services in the area. We saw for example, that emergency admissions to A&E were slightly lower than most other practices in the CCG.

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 and anaphylaxis. We noted a good skill mix among the doctors with some GPs specialising in diabetes, minor surgery and joint injections. Other GPs would refer internally to those GPs to allow them to offer these procedures.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

We saw that staff appraisals had been carried out for administration staff but nurses we spoke with told us that the nursing appraisals were overdue and we saw from their records that this was the case. However, they did report that they had fortnightly meetings with a specific GP who was responsive to any training requirements they identified and would take them to the partners to be approved. They reported being well supported in their role.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, one member of the care team was undertaking a diploma in health and social care and showed us evidence of a significant portfolio of training to support them in their new role, such as new patient checks, 24 hour blood pressure monitoring and injection technique.

The practice was a training practice and doctors who were training to be qualified GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with who confirmed they received immediate access to advice from senior clinicians and regular tutorials.

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 and cervical cytology.

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 system in place to deal with abnormal results which were flagged in red. Those GPs who job shared were responsible for dealing with these before leaving on the day and any new ones would be dealt with by their job share partner. For full time GPs, whilst the practice operated a 'buddy' system for absence, this did not include reading and actioning letters. This was reliant on reception staff to notice any urgent

Good

Are services effective?

(for example, treatment is effective)

details. The GPs acknowledged during our inspection that this process could be more robust and agreed to review this. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for 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). From discussions with the GPs it was evident that they knew their patients well and were able to identify those who may have been at high risk of admission to hospital and communicate with them as necessary.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. Invitations to these meetings included the district nurses, palliative care nurses and the health visitor. The practice reported that it was sometimes difficult for all external staff to attend but they communicated any relevant information to the team. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice had specific staff who dealt with data management in the practice. They 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 had staff trained to add specific additional tasks and templates to share information, for example transfer of information such as GP to GP transfer. They had also set us systems to collect, code and update care records for patients identified in the avoidance of unplanned admission criteria. The practice referred patients to secondary care using 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). Staff reported that this system was easy to use.

The practice has also signed up to the electronic Summary Care Record and had systems in place to upload and ensure information was up to date and correct. (Summary Care Records provide 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. All staff were fully trained on the system and 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.

Consent to care and treatment

We found that GPs were aware of the Mental Capacity Act 2005, 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 and had a section stating the patient's preferences for treatment and decisions. 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 written consent was obtained and scanned into patient's electronic patient notes.

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.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a health check with the health care assistant to all new patients registering with the practice. We spoke with the health care assistant who confirmed this and told us about her role. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. This was supported by the practice's commitment to personal lists and continuity of care which allowed the GPs to know their patients and the issues that were important to them.

The practice were planning to offer the NHS Health Checks to patients aged 40 to 75 years in the near future and the data staff were setting up templates to facilitate this. They 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 who were reviewed annually and offered an annual physical health check.

The practice's performance for cervical smear uptake was 78%, which was slightly lower than others in the CCG area. The practice had a robust system for call and recall of these patients in line with national recommendations. They advertised the availability of chlamydia testing for patients aged between 15 and 24 years and testing kits and information were available from the practice nurse. The practice offered family planning and contraceptive advice for a wide range of contraceptive options.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance and provided scheduled and unscheduled appointments. Last year's performance for all immunisations was 97.5% which was above average for the CCG of 96.6%. The practice were able to refer families to a local service which offered a programme to help families with childhood obesity problems. Two of the female doctors also carried out a weekly surgery in a local boarding school and were available to the school nurses for advice.

All patients in the practice had their own named GP and patients over 88 years were included in the avoiding long term admissions register and had personalised care plans which were reviewed regularly. The practice offered the shingles vaccine to those patients who met the criteria and participated in a catch up programme for those who had not taken up the service initially.

The practice had a robust system for calling patients for review who suffered with long term conditions such as diabetes, asthma, chronic obstructive pulmonary disease and heart disease. We saw that these checks involved procedures such as, a diabetic foot check, retinal screening, spirometry and electro-cardiogram. They had a GP with an interest and additional training in diabetes who worked with the nurse and liaised with the consultant at the hospital regarding treatments and care.

The practice had access to resources for patients with mental health issues by means of the improving access to psychological therapies (IAPT) which GPs could refer to as necessary. The practice also employed a counsellor for a number of sessions a month.

In the waiting area we saw a range of leaflets and health promotion materials regarding, for example, the human papilloma virus (HPV) vaccine and pulmonary rehabilitation. There was also signposting information to services such as, parent drug awareness, feeling sad at 65 and AgeUK on display in the reception and waiting areas.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The GPs told us that part of the practice vision was to maintain strict personal patient lists to promote continuity of care. We spoke with six patients during our inspection who talked positively about their experience with the practice. They told us they liked to see their own GP and could normally do this unless it was an emergency. They reported receiving excellent care at the practice and confirmed they had their own named GP. We reviewed the latest feedback from the national patient survey which aligned with these comments. For example 79% of patients reported being able to see their own preferred GP which was higher than the average for other practices in the area of 63%. We noted that 90% of respondents reported that the GP was good at listening to them and 94% felt that the GPs were good at treating them with care and concern.

We reviewed comments cards left for us by patients at the practice. We received 32 comment cards and all cards without exception reported high levels of satisfaction with the care received by staff at the practice. We noted a high number of positive comments from patients who specifically referred to their own GPs by name and that almost every GP was mentioned.

Patients gave examples of experiencing good care when they had needed an urgent appointment and had to be seen by another practitioner, their own doctor had made contact with them to support them. We noted that comments had been made from a variety of patients groups including those with children, older people and those with long term conditions remarking on the kindness and caring nature of the doctors and nurses and their willingness to spend time explaining their care and treatment to them. Patients reported that the reception staff were also always kind and treated them respectfully and that the staff in general were efficient and helpful.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw that there were screens provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The nurse told us that the door was locked when carrying out intimate examinations.

We observed how the reception staff dealt with patients and saw that they were polite and helpful and spoke discreetly. From the comment cards we looked at, we noted that patients had mentioned the doctors were respectful and non-judgemental. 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. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

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 86% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results.

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 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language although this was infrequently used as the majority of the practice population had English as their first language.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. We saw from comments cards that patients had given examples of when the doctors had spent time helping them understand their newly diagnosed conditions and had been excellent at organising treatment for them. The patients we spoke with on the day of our inspection were also consistent with these comments. Patients had also commented that the doctors and nurses were compassionate and understanding when they presented with anxiety and the doctors put them at ease.

We saw that there were notices in the patient waiting room informing patients and relatives how to access a number of support groups and organisations and services, for example, AgeUK, parental drug awareness. The practice's computer system alerted GPs if a patient was also a carer and we saw notices providing information regarding carers' information.

Staff told us that if families had suffered a bereavement, their usual GP contacted them if appropriate and the necessary support would be offered.

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.

We saw that the practice engaged regularly with the local clinical commissioning group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, the practice had addressed prescribing and had made some improvements to be more in line with other practices in the CCG. They had also analysed the practice referral rates to secondary care, although they were not an outlier in this area. They had become involved in two initiatives to improve patient care, one regarding patients at risk of urine sepsis and the other concerning childhood obesity which involved a 17 week education programme for families with obese children.

The practice had experienced difficulty in forming a patient participation group (PPG) as patients were reluctant to become involved due to time constraints and work commitments. In response to this the practice had formed a virtual PPG which involved patients reporting any comments and views online. They had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the virtual PPG, for example, introduced extended hours and early morning phlebotomy appointments.

Tackling inequity and promoting equality

The practice population was not from an area of high deprivation and there were a higher than average number of patients in the 35 to 54 year age group who were employed. The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services which could be arranged as necessary although the majority of patients were English speaking.

The practice manager told us they utilised a programme called 'Community Navigator' to signpost patients who may have needed additional support in the community. This provided a link for patients with the organisations who could facilitate this support.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was arranged over two floors for consultations. As the practice was an old building there was no access for wheelchairs from the front. They had arranged wheelchair access via the back of the building and the corridor and waiting room on the ground floor level was adequate to manoeuvre a wheelchair or pushchair. They had investigated the installation of a lift but this was not possible. For those patients who had mobility problems arrangements made for them to were seen on the ground floor.

Access to the service

We saw that appointments were available up to six weeks in advance and were available online, by telephone and bookable at reception. Appointments were available from 8am until 6.30pm every day with extended hours appointments available from 7.30am to 8am and 6.30pm to 8pm on Tuesday, Wednesdays and Thursdays on a rota basis. The practice had also been involved in the Prime Ministers Challenge Fund initiative where they were part of the Watford Care alliance. This involved offering appointments to patients from 8am to 8pm seven days a week at the practice or at a local hub accessible to all patients whose practice was involved. The initiative ended in March 2015 and there were no plans to continue this. The practice had also introduced an embargo on appointments to ensure that patients could be seen on the day.

There was comprehensive information available to patients about appointments on the practice website which included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also details to ensure patients received urgent medical assistance when the practice was closed and information on the out-of-hours service was provided. The practice had a specific GP who visited the local care homes on a weekly basis.

Patients we spoke with and comment cards we looked at confirmed that patients were satisfied with the

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments system. They confirmed that they could see a doctor on the same day if they needed to and also said they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. We looked at the complaints policy and procedures which were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for dealing with all complaints in the practice and ensuring any actions were completed.

We saw that information was available in the waiting area to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at five complaints received in the last 12 months and found that these had been dealt with appropriately.

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 shared.

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 demonstrated to us that they had a clear vision to deliver high quality care, person centred care, maintain good access and promote good outcomes for patients. They reported their commitment to continuity of care and strict personal lists in order to achieve this vision. They were also committed to ensuring the highest standards in their role as a training practice, ensuring robust systems to support trainees. We noted there was a 'buddy' system in place to maintain continuity when the named GP was on leave.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

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 several of these policies and procedures and saw that some of these were out of date and needed review. The practice manager told us that they were in the process of updating all policies and this was work in progress. We noted that they had a manual for junior doctors and locums providing information and direction regarding the practice.

There was a clear leadership structure with named members of staff in lead roles. For example, there were specific GPs who specialised in certain areas, such as diabetes and safeguarding. There was also an allocated GP to provide support to the practice nurses. They held fortnightly meetings with them and discussed any clinical issues they may have needed help and advice with. We spoke with nine 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 it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

We saw that the practice carried out clinical audits which it used to monitor quality and systems to identify where action should be taken, for example, a six week audit of insertion of intra-uterine devices.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their individual risk logs, which addressed potential issues, such as fire and legionella. We saw that risks were regularly discussed at team meetings. Risk assessments had been carried out where risks were identified and whilst actions had been taken these were not always recorded in a log.

The practice held weekly meetings of partners and fortnightly meetings of nurses but reception and administrative staff reported they did not have meetings. The practice manager shared information they considered relevant to these staff but there was no formal meeting on a regular basis. Staff reported that they would find this beneficial. We looked at minutes from meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that clinical meetings were held regularly, at least fortnightly for nurses and weekly for GPs. Whilst the reception and administration staff did not have regular meetings, they did tell us that there was an open culture within the practice and they could raise issues at any time if they felt they needed to.

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 paper records of the staff handbook but the practice manager told us this was available to all staff on their computers. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through comment cards, complaints and via their virtual patient participation group. This was a facility where patients reported their views online regarding the service the practice offered. They completed surveys online and

Are services well-led?

Good

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

offered ideas and suggestions. The practice had experienced difficulty in getting a representative group therefore had adopted this virtual method to gain feedback.

We saw the analysis of the last patient survey and results and actions agreed from these surveys are available on the practice website. The practice had looked at the results of patients comments from the survey they had conducted and had investigated feasibility of the installation of a lift. This was not possible to do due to structural reasons but the practice explained this in feedback to patients and arrangements were made to see patients with mobility problems on the ground floor. The practice had also offered extended hours since October 2013 in response to patients' feedback, providing early morning phlebotomy appointments and early and late evening GP appointments and had also upgraded the telephone system.

The practice had gathered feedback from staff through appraisals and discussions on an ad hoc basis. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved in the practice but suggested that this could be improved with more formal meetings perhaps on a three monthly basis.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The nursing staff told us that they were supported by a specific GP which they found very beneficial. They reported that they were currently awaiting their appraisal for this year but that this process allowed them to identify training and development needs. We saw that administrative staff had received their appraisal and staff confirmed that this had taken place. We looked at three staff files and saw appraisal documentation and a personal development plan. Staff told us that they felt supported in their roles and that the practice was very supportive of training.

The practice was a training practice and provided support to fifth year medical students newly qualified doctors and those training to be GPs. Trainees spoke positively about the support they received from the practice. They told us they had extended appointments, immediate access to advice from senior GPs, a debrief after every training session and regular tutorials.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and we saw that the practice improved outcomes for patients as a result, for example, ensuring appropriate contact details for other agencies to enable communication when required urgently to discuss patients' needs.