Little Bushey Surgery

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?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Little Bushey Surgery on 03 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, responsive and well-led services. It also provided a good service for mothers, babies, for children and young people, for the working-age population and those recently retired as well as for people experiencing poor mental health.

The practice was outstanding for providing caring services. It was also outstanding for providing services for older people, for people with long term conditions and for people whose circumstances may make them vulnerable.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, it was the only practice in the area that proactively monitored the care of patients with cardio-vascular conditions through regular testing and treatment known as a level four anti-coagulant service.
- The practice's approach to patients with coronary heart disease (CHD) had resulted in fewer admissions for CHD compared with the CCG and the rest of England.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.

Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the National Patient Survey.
- 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.
- Practice staff had been consulted about and had contributed to the development of the practice's mission statement to provide safe, patient-centred care.
- Staff were given responsibility for key aspects of the practice's work with patients with designated champions for bereavement, vulnerable families and carers.

We saw some areas of outstanding practice including:

- The practice's proactive and dynamic approach to quality monitoring was highly effective giving rise to on-going change and improvement. This was demonstrated by action that the practice had taken to reduce emergency admissions to hospitals. They had done this by making additional locum appointments available during the winter months. This initiative resulted in fewer admissions to hospital of older people and people with long term conditions compared to local and national averages. The practice had been influential in enabling the rest of the clinical commissioning group (CCG) to take this up and this had also resulted in a corresponding reduction in emergency admissions across the CCG area.
- The practice was outstanding for its caring culture as demonstrated by data from the National Patient Survey, patient interviews and views expressed on comment cards. Survey data showed the practice was rated higher than other practices in the area and in England for all aspects of caring practice, with some areas being rated as significantly higher.

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 safe and is rated as 'good'.

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. Medicines were properly stored and monitored and there was a safe system for dealing with repeat prescriptions. The risks of a healthcare associated infection were mitigated through good infection control techniques. There were enough staff to keep patients safe, with enough, appropriately maintained equipment to ensure they worked safely. Staff could respond effectively to a medical emergency. The practice had a robust business continuity plan to ensure it could continue to offer services in the event of a major incident. A member of the staff was designated as vulnerable families' champion whose role was to follow up any anomalies in the treatment of children, such as missed appointments, and to liaise with community health services in relation to children at risk.

Are services effective?

Good

The practice is effective and is rated as 'good'.

Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. Guidelines were positively influencing and improving practice and outcomes for patients.

The practice used a holistic, dynamic and proactive quality monitoring process to improve patient outcomes. This involved regular monitoring of the most up to date outcome data from a variety of sources and peer discussion of scenarios relating to patients unmet needs and learning arising from that. All quality activity was co-ordinated by a fortnightly clinical meeting that directed audit activity and implemented changes in practice. The latest available data showed that the practice was performing well when compared to neighbouring practices in the Clinical Commissioning Group (CCG) and the rest of England. This was significantly better for outpatients' referrals and admissions to hospital for long term conditions such as cancer and respiratory illnesses.

The practice carried out a winter initiative that provided additional locum appointments to offset the number of unplanned hospital

Summary of findings

admissions. GPs also acted as named care co-ordinators for people most at risk of unplanned hospital admissions. Data showed that the practice had a corresponding drop in emergency appointments during the periods the initiative operated.

The practice proactively managed the care of patients who were at risk of cardio vascular disease through regular testing and treatment known as a level four anti-coagulant service. Nationally available data showed the practice had a high proportion of patients with coronary heart disease (CHD) but a significantly lower prevalence of hospital admissions arising from CHD.

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?

Outstanding 

The practice is caring and is rated as 'outstanding'.

National Patient Survey data from January 2015 showed that patients rated the practice higher than others for all aspects of care; in some cases this was significantly higher. Interviews with five patients during inspection and the views expressed on 27 comment cards universally supported the data.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Some patients and some of the comments cards reported specific examples of caring and compassionate treatment.

Patients who were recently bereaved were contacted by a GP to determine their wellbeing and ascertain their support needs. Bereavement support was co-ordinated by a member of staff designated as bereavement champion.

The care and treatment of patients who were carers was co-ordinated by a member of staff designated as carer's champion.

The care and treatment of vulnerable families and their children was monitored by a member of staff designated as a vulnerable families' champion.

Information for patients about the services available was easy to understand and accessible. Staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good 

The practice is responsive and is rated as 'good'.

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The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. This was particularly the case with a winter pressure initiative that this practice had implemented resulting in a reduction in the number of emergency admissions for the five month period it was in operation. The initiative was adopted by other practices in the CCG locality area and subsequently by the CCG itself.

Patients found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. 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 and other stakeholders.

Are services well-led?

Good

The practice is well-led and is rated as 'good'.

Practice staff had contributed to the development of the practice's mission statement to provide safe, patient-centred care. Staff had responsibility for key aspects of the practice's work with patients and this in turn encouraged commitment to the practice vision and the maintenance of a caring and learning culture.

The practice's proactive and dynamic approach to quality monitoring was highly effective giving rise to on-going change and improvement. This led to consistently good outcomes for patients demonstrated by fewer admissions to hospital of people with long term conditions compared to local and national averages.

The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice acted upon feedback from patients and planned improvements around that feedback.

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

Outstanding ☆

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

Nationally reported data showed that admissions to hospital for conditions commonly found in older people such as cancer, diabetes and chronic respiratory conditions, were fewer than the averages for the Clinical Commissioning Group (CCG) and nationally. This reflected the practice's proactive approach to monitoring the care and treatment of these patients. Data for the practice was significantly better for patients with coronary heart disease. This was reflective of the practice's advanced monitoring and treatment service for patients at risk of cardio-vascular conditions, the only service of its type in the CCG locality.

The practice worked with multi-disciplinary teams to support the care of older people, including those patients who were at risk of hospital admissions and those who were receiving end-of-life care. Patients were referred to a local community navigator service to help them gain access to local support services. Patients at risk of unplanned hospital admissions had their care co-ordinated by a named GP. Some patients were referred to a 'virtual ward' service, a local health and social care multi-disciplinary service aimed at providing a pathway that supported people to stay in their own homes. The practice discussed the evolving individual needs of their registered patients receiving the virtual ward service on a weekly basis.

Longer appointments and home visits were available for older patients and those living with dementia.

The practice had implemented a winter pressure initiative aimed at providing additional locum appointments during winter months to support those patients most at risk of hospital admissions. The data available showed that there was a fall in the number of admissions during this period. The practice had been influential in enabling other practices in the locality and the other three localities in the CCG area in receiving additional funding to support the initiative throughout the area.

People with long term conditions

Outstanding ☆

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

The practice used a holistic, dynamic and proactive quality monitoring process to improve patient outcomes involving the use of benchmarking data, peer discussions on individual cases, clinical

audits and strategic clinical direction. The latest available data showed the practice was performing highly compared to others in the Clinical Commissioning Group (CCG) and the rest of England, significantly so for outpatients referrals and admissions to hospital for long term conditions such as cancer and respiratory illnesses.

The practice's proactive approach to monitoring the care and treatment of patients with long term conditions led to better outcomes for those patients. This was particularly the case for patients with coronary heart disease (CHD). Data showed that, whilst there was higher prevalence of patients with CHD compared to the CCG and the rest of England, the prevalence of patients suffering heart failure and the prevalence of patients admitted to hospital for CHD was lower.

Data showed good outcomes for patients with diabetes in relation to blood pressure monitoring and retinal screening.

GPs were named leads for chronic disease management. Nursing staff were supported by a robust clinical supervision process. 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 such as the local virtual ward service.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

A vulnerable families champion was 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 emergency department attendances. Immunisation rates were comparable with other practices for all standard childhood immunisations.

Children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. There was effective joint working with midwives, health visitors and school nurses. The practice had recently carried out a safeguarding audit and had improved their practice as a result.

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).

Summary of findings

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, such as extended hours between 7am and 8pm twice weekly. 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

Outstanding ☆

The practice is rated as outstanding 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 carried out annual health checks for people with a learning disability. The practice's vulnerable families' champion ensured that children living in travelling communities were called in for childhood immunisations and that any missed appointments were followed up. Longer appointments were available for people with a learning disability and patients with complex health needs.

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 such as through a community navigator service. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours.

The practice's medicine audits had led to management plans for patients receiving specific medicines that required close monitoring and for more effective decision making in relation to patients prescribed with non-steroidal anti-inflammatory drugs.

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). Ninety-five percent of people experiencing poor mental health had received an annual physical health check; 97% in relation to those living with dementia. 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.

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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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection and collected 27 comments cards completed by patients in advance of our inspection. All of the patients we spoke with reported that their GP and the nurses were courteous, considerate and compassionate. Patients also told us that all the reception staff were polite and had a pleasant manner.

None of the comment cards indicated any negative opinions and all of the cards reported wholly positive experiences of patients. Some of the cards were overwhelmingly positive, referring to doctors and staff by name and singling out individual examples of kindness, care and compassion.

Patients' views of their experiences as shown on the National Patient Survey were consistently higher than elsewhere in the clinical commissioning group (CCG) area and in England.

Ninety-four percent of patients stated they would recommend the practice. This was significantly higher than the rest of the CCG area (82%) and among the best ratings compared with the rest of England (78%).

Ninety-four percent of patients stated that their overall experience of the practice was good or very good; this rating, too, was higher than the CCG average (87%) and among the highest range of ratings nationally where the average was 85%.

Ninety-five percent of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%. 96% of patients felt the nurses gave them enough time compared with 92% of patients in the CCG area and nationally.

Ninety-eight percent said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%. 99% said they had confidence and trust in the nurses as opposed to 98% and 97% for the CCG and England respectively.

Ninety-five percent of patients said that the GP was good at giving them enough time compared to 87% for both the CCG area and for England. 96% said the nurses were good at giving them enough time compared with 92% in the CCG and England.

Outstanding practice

The practice's proactive and dynamic approach to quality monitoring was highly effective giving rise to on-going change and improvement. This led to consistently good outcomes for patients demonstrated by data relating to outpatient referrals and to the prevalence of admissions to hospital for long term conditions, such as cancer, respiratory illnesses and coronary heart disease. The practice had taken action to reduce emergency admissions to hospitals by making additional locum appointments available during the winter months. This initiative had resulted in fewer admissions to hospital of older people and people with long term conditions compared to local and national averages. The practice had been influential in enabling the rest of the clinical commissioning group (CCG) to take this up and this had also resulted in a corresponding reduction in emergency admissions across the CCG area.

The practice was outstanding for its caring culture as demonstrated by data from the National Patient Survey, patient interviews and views expressed on comment cards. Survey data showed the practice was rated higher than other practices in the area and in England for all aspects of caring practice, with some areas being rated as significantly higher.

Little Bushey Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by a GP specialist adviser.

Background to Little Bushey Surgery

Little Bushey Surgery is a general practice that provides primary medical care for just over 6,000 patients who live in the town of Bushey, Hertfordshire and the surrounding area.

The practice operates from premises in California Lane, Bushey, Hertfordshire, WD23 1EZ.

According to Public Health England, the patient population is predominantly white British with a higher than average percentage of women patients aged between 40and 49 year as compared with the rest of England and a higher population aged over 65 years. There is a less than average percentage of patients in the age range 20 to 39 years.

Little Bushey Surgery has four GPs, three of whom are partners in the practice. There are two practice nurses who run a variety of clinics as well as a health care assistant.

There is a practice manager and a team of eight non-clinical, administrative and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice provides a range of clinics and services, which are detailed on their web-site and commented upon throughout this report, and operates generally between the hours of 8am and 6.30pm, Monday to Friday. There are additional hours from 7am to 8am on Monday and Wednesday mornings. Generally, appointments are available between 8.30am and 11am and then again between 3.30pm and 6pm. Telephone consultations are also available after the morning surgery hours.

The practice does not provide their own out-of-hours service and so, outside of practice hours, primary medical services are accessed through the out-of-hours provider, Herts Urgent Care.

There have been no previous concerns in relation to this practice historically.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider 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.

This provider had not been inspected before and that was why we included them in this round of inspections in the Herts Valleys Clinical Commissioning Group (CCG) area.

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

Detailed findings

How we carried out this inspection

We conduct our inspections of primary medical services, such as Little Bushey Surgery, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

We carried out an announced visit on 03 March 2015. During our visit we spoke with three of the GPs, the practice manager, members of the nursing team and administration staff.

We spoke with five patients using the service on the day of our visit. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed 27 CQC comment cards completed by patients using the service prior to the day of our visit where they shared their views and experiences.

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

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

We also look at how well services are provided for specific groups of people and what care is expected for them. Those population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

We found that Little Bushey Surgery had an open and transparent culture amongst its staff about keeping people safe. This was supported by clear procedures for escalating incidents and allegations of abuse. Staff at all levels were encouraged to communicate any incidents and concerns arising from their work straightaway so they could be discussed and dealt with immediately. Any matters requiring further investigation or more detailed discussion, and any complaints by patients were escalated through a process for analysing significant events.

We saw that the practice took account of a number of different sources of information to help them to understand whether or not they were operating safely. This included medicine and healthcare product safety alerts. These, along with any actions arising from them, such as restrictions on prescribing particular medicines, were logged and disseminated to relevant staff. GPs carried applications on their mobile 'phones so that they were apprised of such alerts as soon as they arose.

We looked at significant events and complaints records, comments received and notes of fortnightly clinical meetings and monthly practice meetings for the previous year. We also looked at the log of safety alerts for the three months preceding our inspection. These records showed that incidents, feedback and concerns were discussed and action taken to rectify any identified safety issues. Outcomes and any learning arising from the incidents were communicated to staff through the monthly practice meetings. This was consistently applied showing the practice had a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and analysing significant events, incidents and accidents. All staff were empowered to report incidents and events and could determine whether an event was deemed to be significant and thus required further investigation. Relevant reporting templates were available for staff to use on the practice intranet. Staff we spoke with demonstrated a broad understanding of the processes for reporting such incidents and knew the extent of their accountability. A non-hierarchical management approach by the senior staff supported this learning culture.

Safety issues and significant events were analysed to determine whether any learning points could be taken from them. These were then discussed as part of the agenda on fortnightly clinical meetings whenever they arose and where key decisions were made about the practice. Significant events that affected the wider practice team were discussed at monthly practice meetings when everyone had the opportunity to learn from them.

We looked at a number of records of significant events over the previous year. These demonstrated that the practice had reviewed the circumstances in depth and had learned lessons from them. For example, we noted that an issue about incorrect labelling of a pathology specimen had resulted in learning for all practice staff about diligent labelling and documentation.

We looked at several examples of significant events and complaints that affected patients where the patient concerned had been given an apology and had been informed of actions the practice had taken to learn from the incident.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a designated lead GP and a deputy for safeguarding children and adults. There were bi-monthly multi-disciplinary primary healthcare team meetings involving the health visiting, school nursing and midwifery services to review and manage risks to vulnerable children. Health visitors and the midwifery team could also speak with the GPs on an ad-hoc basis if they had concerns about particular families.

The practice had designated one of the administrative team as a vulnerable families' champion. This staff member followed up missed appointments at the practice or at the hospital by any children, such as immunisation appointments, whether or not they were identified as being vulnerable or at risk. They also regularly liaised with the health visitors to ensure vulnerable children were highlighted. The practice followed up any notifications from the local hospital trust about children who had a high number of emergency department attendances by carrying out either telephone or face-to-face consultations.

The practice had separate, accessible safeguarding adults and safeguarding children policies and a child

safeguarding protocol describing action to take if staff had concerns about a child. This was supported by posters in each area highlighting action to take if staff were worried about abuse of any vulnerable patient.

There was a system highlighting vulnerable patients on the patient records system. Staff we spoke with told us this included information on specific issues so they were aware of any relevant background when patients attended appointments; for example children who were subject of a child protection plan or those who were looked after by the local authority. We saw that correspondence received from the local authority about such children was held in a separate, secure folder and distributed to clinical staff to read and raise their knowledge of particular families. The practice contributed written reports to all child protection processes and in some cases the lead GP attended child protection conferences in person.

All staff had received relevant training on safeguarding to the level appropriate to their role and we asked medical, nursing and administrative staff about their most recent training. Staff could recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities to document safeguarding concerns and how to contact relevant agencies during and out-of-hours. All staff we spoke with knew who their lead was and how to escalate concerns they had about particular patients. We learned of occasions when the process for alerting the local authority to concerns had been effective.

The practice had carried out a safeguarding children audit in September 2014 using a self-assessment toolkit developed by the Royal College of GPs. This had shown the practice to be compliant with 22 of the 24 criteria assessed. Actions had been identified to ensure that the other two criteria would be met by the time the practice re-audit this. For example, the local procedure was for pregnant women to self-refer to the community midwife team for ante-natal care. This meant that the practice were unsighted on new pregnancies and could not assess or share information about women with previous children who were known to be at risk; one of the criteria measured in the audit. The practice had raised this for discussion at the forthcoming locality meeting of the Clinical Commissioning Group (CCG) in order to address this.

Patients' individual records were written and managed in a way to help safeguard patients' information. Records were kept on an electronic system, which collated all communications about the patient including scanned copies of correspondence from hospitals or other services. Access to this system was through a smartcard and a unique password. The practice used minimal paper patient records. Where paper records were used these were filed away securely after use in accordance with a clear desk policy which required all staff to lock away paper documents with confidential personal information.

Medicines management

We spoke with a practice nurse and checked medicine stocks. Medicines were stored securely and were only accessible to authorised staff. We saw that the cold chain was maintained for the storage of temperature sensitive medicines, such as the flu vaccine, from the time they were received at the practice to the time they were administered. There was a system for monitoring the fridge temperatures daily so that the practice was assured the vaccines remained viable and safe to use. The vaccine stocks were monitored regularly and rotated to ensure that the oldest medicines were used first.

There were clear procedures for the management of medicines that minimised the potential for error. For example, the nurses worked with patient group directions (PGDs) that were up-to-date, signed and held on the practice intranet. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before they present for treatment, such as vaccinations.

There was a safe system in place for managing repeat prescriptions. Prescriptions could be ordered by hand, by post or by using the recently introduced online system. Prescriptions could also be collected by local pharmacies if this was the patient's choice. There was a safe system for receiving, checking, authorising and re-issuing prescriptions. All prescriptions were reviewed and signed by a GP before they were issued to the patient. Staff were made aware of the current prescription status for each patient by way of a 'pop-up' on the records management system. For example, it was clear how many repeat prescriptions could be authorised before patients needed to be seen by a clinician to have their medicines reviewed.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice's monitoring systems and kept securely at all times.

Good

Are services safe?

We saw that prescriptions for high risk medicines were managed safely and according to protocols produced for that purpose. For example, the high risk medicines used in the treatment of rheumatic disorders was managed according to a protocol that included near patient testing (a process involving the testing of patients' blood on-site in the practice instead of sending it off for laboratory analysis). This was also the case for high risk medicines used in the treatment of patients at risk of cardio-vascular diseases.

The practice had also audited its performance in prescribing particular medicines known as hypnotics and those known as non-steroidal anti-inflammatory drugs to ensure its prescribing practice for these medicines was safe. This is reported in more detail under 'Effective' below.

The practice did not generally stock controlled drugs (medicines categorised as such because they require specific arrangements for storage and monitoring due to their risks) other than a very small stock of a particular opioid analgesic. This small stock was due to be destroyed and we saw that, in the meantime, it was stored and logged properly in accordance with the relevant guidelines.

Medicines for use in the event of a medical emergency were accessible to staff and were monitored regularly to ensure they remained within their expiry dates and were safe to use.

Cleanliness and infection control

The practice was clean and tidy on the day of our inspection. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness. The practice was cleaned by an independent, established clinical cleaning contractor whose staff followed a daily, weekly and monthly cleaning schedule. The schedules were posted prominently in each treatment or consulting room and in each public area of the practice. Individual clinical practitioners were responsible for maintaining a hygienic work area in their respective rooms by following standard infection prevention practice. This included wiping down surfaces and cleaning equipment after each use as well as checking each morning that the room was clean and ready for use. However, other than this visual check by individual practitioners and an informal ad-hoc walk-around, there was no means of recording whether the cleaning was thorough or carried out to required standards, such as a log of regular checks or internal inspection.

An infection control policy was available for staff to refer to on the practice intranet. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff described how they would use these in order to comply with the policy. There was also a protocol to be followed in the event of anyone suffering a 'needle-stick' injury.

Hand hygiene posters were displayed and there were soap, gel and paper towel dispensers for staff to use in order to comply with Department of Health (DH) guidance. We saw that curtains were cleaned every six months in accordance with that guidance.

The practice had a lead nurse for infection control who had been recently delegated with this responsibility. The lead nurse had carried out an infection control audit in January 2015 using a recognised self-assessment tool. We saw that some areas for improvement had been identified and that and action plan was being used to rectify these. For example, whilst flooring in high risk areas, such as the treatment room and the toilet, met the specification set out in the DH guidance, the practice had a plan to replace flooring in the GP consultation rooms with a higher specification by June 2015. The practice also planned to fit elbow taps in all areas by the end of June 2015. Some actions from the action plan had been taken already, such as replacing the bins in the toilet area with standardised pedal operated bins.

Clinical and hazardous waste was properly disposed of in colour coded bins and was regularly collected by the local authority. This was also the case for used sharp instruments. Infection control training formed part of each new staff member's induction programme and all staff had recently received training in dealing with spillages. We saw that there were two spillage kits in the reception area for staff to use for such an event.

The practice had carried out a risk assessment of its water supply in January 2015 in relation to the risks of water-borne infections such as legionella. As a result the practice had begun monthly testing of the water temperatures to ensure the water supply was capable of reducing the risk of harmful micro-organisms.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was well equipped

with adequate stocks of equipment and single-use items required for a variety of clinics and services, such as the asthma clinic, blood taking and vaccinations. The practice also had a patient self-assessment area where they could use a patient operated blood pressure machine to measure this prior to seeing the GP or the nurse. This area was clean and well maintained and had clear instructions for using the machine and printing out the result.

Staff told us that all equipment was tested annually and serviced regularly and we saw records that confirmed this. The last service date for most items, such as blood pressure monitors, a spirometer and an electro-cardio gram (ECG) machine was August 2014. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

The practice recruitment policy and records we looked at contained evidence that proper recruitment checks had been undertaken prior to people being employed. We saw proof of identification, references, qualifications, registration with the appropriate clinical professional body and, where applicable, criminal records checks through the Disclosure and Barring Service (DBS). All medical and nursing staff had been checked through the DBS as had those non-clinical staff who occasionally performed the role of chaperone. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected.

We saw that the practice planned its staffing requirement around the services it provided. This was in accordance with a staffing policy underpinned by a risk assessment carried out by the practice manager and based on the historic experience of meeting the needs of the local community over time. For example, the practice had calculated that it required 23 GP sessions per week covered by three whole-time-equivalent GP posts and ten nursing sessions. The staffing policy also stipulated how many non-clinical staff were required to support the delivery of the service.

There was provision for both short-term absence and long term absence as well as a contingency for an increase in demand due to an unforeseen event such as an unpredictable public health issue. This ensured that there were enough competent staff on duty with the appropriate skill mix at all times to support safe care and treatment. We saw that staffing had remained stable; there was evidence of a low staff turnover and minimal use of locum staff for short term cover.

The practice had carried out a demand audit during the autumn and winter months of the 2011 to 2012 financial year in order to assess whether additional GP appointments would be required to sustain the level of service. As a result of this audit, the practice deployed an additional locum GP between November and March inclusive for the past three years. This led to an additional 20% GP appointment capacity to enable the practice to provide access to a GP to vulnerable patients at a time when demand was at its greatest. We have reported on this initiative in greater detail under 'Responsive' below.

Monitoring safety and responding to risk

The practice had procedures in place to deal with potential medical emergencies. All staff had received annual training in basic life support in September 2014. The training included cardio-pulmonary resuscitation and the recognition of anaphylactic shock – a severe shock due to an allergic reaction, for example, to a vaccination. This also included training in the use of an automated external defibrillator (AED), a device used to attempt to restart the heart in a medical emergency; a recommended item of equipment according to guidance issued by the Resuscitation Council.

The AED and emergency oxygen were readily available and checked monthly to ensure they operated safely. The practice carried a small stock of medicines for use in the event of a medical emergency such as chest pain, a diabetic emergency, a serious respiratory problem or anaphylactic shock. We saw that emergency medicines were checked monthly to ensure they were within their expiry dates.

We found that staff at all levels were empowered to raise immediate concerns they might have about any particular patient with a clinician, even if they were unsure about what they had identified. Staff we spoke with said they were confident in recognising patients who might arrive at the practice with acute clinical needs requiring a clinician's input as a priority. We learned of instances when this had occurred.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

There was a comprehensive business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to any event or major incident. These included unplanned staff sickness, the loss of the practice computer system, significant adverse weather, loss of the water supply or electricity or an epidemic. The sections of the plan were aligned to specific risk assessments for each of these key areas of the service where each risk was assessed and control measures identified. The document was kept under review and hard copies were located both on and off-site.

The plan showed where the practice would re-locate to if the premises became unsuitable (a local church hall) and a check-list of essential equipment for staff to bring with them. There were contact numbers for the CCG, the local NHS England area team, and other key organisations such as utilities companies.

We saw records that showed staff were up to date with fire training. The fire alarm was tested weekly. And there were regular fire drills. The practice had a designated lead for health and safety who was supported by a comprehensive health and safety policy that was available to all staff on the practice intranet.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. This included the use of best practice and clinical guidance described by the National Institute for Health and Care Excellence (NICE) and pharmaceutical guidance by the British National Formulary (BNF). Additionally, clinicians made use of local guidance from local commissioners of health services such as the Clinical Commissioning Group (CCG). For example, one of the GPs chaired the meetings of the CCG locality group for the Hertsmere area where new or emerging guidance and prescribing issues were discussed.

Guidance was cascaded to the clinical team during fortnightly clinical meetings to ensure that all staff would benefit from the most recent updates and their understanding enhanced through peer discussion. Moreover, the clinicians made use of a programme on the records management system and a mobile 'phone application that enabled them to refer dynamically to NICE and BNF guidance during consultations.

The practice used their computer records system and the Quality and Outcomes Framework (QOF) to identify and monitor particular patients within certain groups and to tailor any interventions according to their need. The QOF is the national data management tool generated from patients' records that provides performance information about primary medical services. For example, the practice identified and recalled patients with long term conditions so that their conditions could be monitored effectively.

In this way the practice had also identified different groups of its patients whose care could be delivered proactively; that is, active recall for monitoring purposes and active management of their treatment according to an individual care plan. These were patients with dementia, asthma, learning disabilities and poor mental health as well as those who were most at risk of unplanned hospital admissions. In the case of people at risk of unplanned admissions, we saw that the GPs acted as named care co-ordinators to oversee and proactively review their care in order to reduce their risk of unplanned admission.

According to the latest data available to us, we noted that referrals and admissions to hospital for long term conditions, particularly emergency admissions were lower than the rest of England and the CCG.

The GPs each held a lead responsibility for the treatment of patients with long term conditions such as diabetes, respiratory conditions and cardio-vascular conditions. In particular, the practice was the only one in the locality to carry out a level four anti-coagulation service; that is, a complete, near-patient testing and treatment service for patients at risk of cardio-vascular conditions carried out on-site. We learned that the practice had offered to provide training on their anti-coagulation work to other practices in the area although this had yet to begin at the time of our inspection.

The practice proactively monitored the care of this group of patients through regular testing and treatment. From nationally collected data, we noted that the practice had a high prevalence of coronary heart disease (CHD) as compared with the rest of England and almost twice as high as the CCG. However, the prevalence of patients suffering heart failure was lower and the prevalence of patients being admitted to hospital as an emergency for CHD was significantly lower than both the CCG and the rest of England. This indicated very favourable outcomes for patients with cardio-vascular conditions at this practice.

The practice also identified a lead person for other areas of interest. For example, one of the practice nurses had a special interest in women's health and carried out 'well-woman' health checks for one session every week whilst another GP had a special interest in dermatology.

We also saw that the practice appropriately coordinated the multi-disciplinary team (MDT), involving the community nursing team and the Macmillan service among others, for the planning and delivery of palliative care for people approaching their end-of-life. We saw that every patient receiving palliative care was reviewed by the MDT at formal bi-monthly meetings to ensure that their specific needs were met.

During our interviews with GPs and staff and throughout our observations we saw no evidence of discrimination when making care and treatment decisions.

Good

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice had a holistic and proactive approach to monitoring quality and improving outcomes for patients involving a number of different but interlinked processes, such as data monitoring, reflective practice and clinical audits. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented in order to assess their effectiveness. The fortnightly clinical meetings played a key role in directing this process, often responding to anomalies identified through the practice's management of patient data. This process was helped by the practice's presence and profile in the local area. For example, one of the GPs chaired the Hertsmere locality group of the CCG, experience that enabled benchmarking data to be interpreted more effectively. Another of the GPs participated in a local medication group. This ensured that topical information about medicines was used to influence prescribing performance and the focus of the practice's audits.

We noted from our own review of data available for the previous year that the practice had a higher rate of prescribing of two groups of medicines known as hypnotics and non-steroidal anti-inflammatory drugs (NSAIDs). Through the use of data monitoring, we saw that the practice had also identified these as areas that required closer examination. As a result, the practice had recently carried out separate clinical audits in respect of these types of medicines that resulted in planned actions to improve outcomes.

For example, an initial audit of prescribing of a particular medicine categorised as a hypnotic carried out in December 2014 led to the practice taking a decision to review every patient who was receiving this type of medicine. This resulted in individualised management plans for the medicine and a pop-up alert on the records system to alert GPs if the patient presented with other conditions to ensure issues were considered at each consultation. We saw that the initial audit of prescribing of NSAIDs from January 2015 had given rise to the use of a decision making tool to support GPs in prescribing decisions. Both of these initial audits had been recently carried out and we learned of the practice's plans to measure the effectiveness of the actions arising from them by completing a second cycle of measurements after six months.

We saw that the practice was consistent in its proactive approach to performance measurement through clinical audits and in using information and guidance to help to interpret results. For instance, an audit of prescribing practices for three groups of higher risk antibiotics had been subject to a two-stage audit cycle for two identical periods at the end of 2013 and 2014. The objective had been to modify practice to ensure compliance with local prescribing guidelines and to emphasise the risks to public health of over-prescribing. The results had been discussed with a local pharmacy adviser to assist the GPs to interpret the results.

The outcome of the audits showed that prescriptions for one particular antibiotic had significantly reduced as a result of a heightened awareness of the local guidance among the GPs. Prescribing for another had reduced to a lesser degree and there was no difference in respect of the third. Further action had been taken to ensure that practice was modified still further, such as introducing desk-top tools in each consulting room to assist GPs in recognising particular indications for these antibiotics. The practice told us of their intention to continue to monitor prescribing to ensure that compliance with local guidelines was maintained. This indicated that the clinical team took a longitudinal view of their performance and its relationship to public health.

During our inspection we also reviewed audits that the practice had carried out in relation to the management of patients with exacerbations of asthma, the efficacy of cervical screening and the use of documentation. In each case, the practice demonstrated that they had implemented changes as a result of a completed two-stage audit or had planned to measure the effect of changes arising from an initial audit.

The practice clinical meetings also considered and learned from specific case studies where assessment and treatment were discussed with a view to ensuring patients' needs were met from a variety of scenarios. These discussions were based on reflective practice and considered situations where patients' unmet needs helped to identify educational needs of the GPs.

As previously reported, the practice proactively monitored the care of patients with long term conditions and those at risk of hospital admissions through individualised care planning, active scrutiny of patient data in relation to attendance and a system of recall. The practice actively

Good

Are services effective?

(for example, treatment is effective)

monitored data from the primary care web-tool, which contains data from a range of sources including Public Health England and the Quality and Outcomes Framework (QOF). This enabled the clinical meetings to make decisions about how to manage their performance in the diagnosis and treatment of common chronic conditions, to target resources accordingly and to assess their quality and productivity. Any concerns about a particular approach, or trends identified from this monitoring, directed the practice's audit activity as described above.

As reported above, our examination of national data showed favourable outcomes for patients with cardio-vascular conditions at this practice compared to the CCG and the rest of England; reflective of their advanced anti-coagulant service. The data also showed that, generally, the practice performed as expected when compared to the rest of the CCG for the management of long term conditions and in some cases, performed better than the CCG. The practice showed us more recent benchmarking data that indicated better than expected performance in a number of areas. For example, the practice had similar figures for cancer admissions even though the prevalence of cancer was significantly higher than the CCG and the rest of England. We also noted there was a significantly lower prevalence of the use of secondary health services from patients at this practice as compared to the rest of England such as referrals to outpatients, general surgery and urology. In particular there were significantly lower emergency admissions as compared to the rest of England as well as admissions for long term conditions. This more recent data reflected older, publicly available data and this showed that the practice was consistent in providing high levels of care over time. We considered this as evidence of the effectiveness of the practice's proactive and dynamic approach to quality monitoring.

Effective staffing

We looked at records and spoke with staff and found that staff were appropriately trained and supported to carry out their roles effectively. This was the case for both clinical and non-clinical staff. All of the GPs had their own areas of expertise that enhanced the service they were able to provide to their patient population. For example, one GP had expertise in diabetes whilst another specialised in anti-coagulation treatment.

New staff received a comprehensive induction programme that introduced them to their role. Non-clinical staff were trained to carry out more than one role; for example, all administrative staff could carry out reception duties so the practice could remain effective during peak times. Non-clinical staff also had particular areas of responsibility ensuring they developed expertise in certain areas. For example, one staff member was designated as the vulnerable families' champion. They followed up missed appointments at the practice or at the hospital by any children and liaised with the health visitor on a regular basis to ensure vulnerable children were highlighted. Other staff had specific responsibility, such as new patient registrations, supporting the cervical screening programme and recalling patients with diabetes.

We saw that all staff received regular training in subjects that are generally considered as key, such as annual basic life support training and annual safeguarding training. Both of the nurses were multi-skilled and had been trained in various aspects of nursing practice so that they, too, could cover the range of clinics that the practice ran, although each nurse tended to specialise in particular areas. For example, one of the nurses principally ran respiratory clinics whilst the other predominantly carried out childhood immunisations. The practice also had a health care assistant who was trained to take blood samples and who was in the process of becoming trained to carry out adult health checks.

The doctors and the nurses had maintained their continuing professional development requirements in order to ensure their continued registration with their relevant clinical professional bodies.

The practice had formal arrangements to provide clinical supervision, an activity that brings clinicians of like professions and skills together to consider performance, skills and knowledge. We learned that the nurses could approach any of the GPs at any time to discuss issue arising from their work and this happened frequently, particularly in relation to work with patients with long term conditions. Additionally, the nursing staff engaged in peer review on a monthly basis with other practice nurses in the locality area where each other's work and specific cases were discussed and learned from. This clinical supervision process was supported by an open leadership style at the practice and an emphasis on learning at work.

Good

Are services effective?

(for example, treatment is effective)

All staff took part in monthly protected time meetings when they discussed learning from complaints, significant events and audits as well as undergoing some of their key training.

All staff received annual appraisals in February every year which identified their learning needs and other development opportunities. Their annual activity was objective driven with a personal development plan agreed at each appraisal. Staff personal objectives were linked to practice performance and objectives. For example, nursing objectives were linked to the practices objective to increase cervical screening and adult health checks. Staff we spoke with told us that they felt supported, skilled and valued.

Working with colleagues and other services

We found that the practice engaged regularly with other health care providers in the area such as the community nursing team, the health visiting team, the emergency department of the local hospital and the local ambulance service. The practice supported patients who were unfamiliar with how to use local health and social services by referring them to a 'community navigator' service. This is a scheme funded by the CCG and the county council to help people find their way around the different services on offer in their area such as befriending services, day-centres and other support organisations.

All records of contact that patients had with other providers were received electronically, by fax or by post. They were scanned into the records system for clinical review by the patient's usual doctor if they were available or by a GP designated as 'duty doctor' for the day if they were not. This ensured that the practice retained clinical oversight of their patients' encounters with other health services and could coordinate any further or follow-up action indicated by them. Those patients who were at most risk from unscheduled hospital admissions were contacted by the duty GP following any discharge from hospital after such an admission. In any event, all patients discharged from a stay in hospital were reviewed by a GP either at the practice, or at their home or care home in order to ensure continuity of care.

We noted that the practice engaged actively with a local 'virtual ward' initiative, a multi-disciplinary initiative involving community health and social care services set up to provide a response to people at risk of hospital admissions and in order to support them with a care pathway that enables them to remain at home. The practice referred patients to this service where they identified patients who were at risk of an unplanned admission. The practice set aside weekly, dedicated slots to engage the virtual ward team to monitor the progress of their registered patients that were using the scheme.

We saw evidence that referrals were regularly the subject of peer discussion at the fortnightly clinical meetings and this helped the practice to ensure they were following standard approaches for referrals.

The evolving needs of every patient receiving palliative care were discussed at bi-monthly multi-disciplinary team (MDT) meetings. As patients neared the very end-of-life, their care plans and any documents that related to their decisions about resuscitation were shared with other providers such as the ambulance service and the out-of-hours service to ensure that specific wishes about their death could be met.

As reported above, one of the GPs chaired the CCG locality group. We saw that this enabled the practice to be influential in the way that services were aligned in the area. Two examples illustrate this. Firstly, we saw that the locality group had been instrumental in setting up a weekend out-of-hours GP service adjacent to the council offices and had produced a range of information for the public to encourage use of this service instead of presenting at the hospital emergency department. Secondly, and of greater significance was the work carried out by this practice to alleviate the number of emergency admissions by employing an additional locum GP during the winter months. This work had directly influenced the adoption of this winter pressure initiative by the locality group to begin with, and by the other three localities in the CCG area subsequently. The outcomes from this initiative are reported on in greater detail below under 'Responsive'.

Information Sharing

The practice used an established electronic records management system to provide staff with sufficient information about patients. The system carried personal care and health records and was set up to alert staff about particular patients, such as information about children known to be at risk or those receiving end-of-life care. For example, for patients who were caring for others, the caring responsibility was marked on the summary record of a patient when they attended the surgery as a patient in their own right so that the social and psychological factors associated with caring could be addressed in care planning.

Good

Are services effective?

(for example, treatment is effective)

The system enabled correspondence from other health care providers, such as discharge letters or blood and other test results, to be scanned and held electronically to reduce the need of paper held records. The system was also the gateway to the 'choose and book' system which facilitated the management of referrals to other services such as the hospital outpatients. This system was readily available and accessible to all staff who were trained in its use.

The practice used the electronic Summary Care Record which enabled faster access to key clinical information about patients for healthcare staff when treating patients in an emergency or out of normal hours. When patients were referred to hospital or other services we saw that a summary of their medical information was included as part of the referral documentation that accompanied the patient to hospital.

Consent to care and treatment

We found that patients' consent to care and treatment was always sought in line with legislation, guidance and the practice's consent policy. This consent was either implied, in respect of most consultations and assessments, or was explicitly documented in patient notes when treatment was explained and offered. Patients we spoke with on the day of our visit told us that they were always provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

We also saw that the practice applied well-established criteria used to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone with parental responsibility. Such instances were recorded fully within patient notes. We also saw that the provisions of the Mental Capacity Act 2005 were facilitated appropriately by the use of a mental capacity protocol that had been distributed to all staff along with a quiz to check understanding. Assessments of patients thought to have limited capacity to consent were carried out diligently and with the involvement of key people known to those patients. This was particularly relevant for patients who had a learning disability or who lived with dementia or about those for whom decisions about resuscitation were in place. We discussed examples of both of these scenarios with the clinicians.

Policies and guidance which supported GPs to reach decisions about consent, including a person's capacity to consent were available on the practice's intranet.

Health promotion and ill-health prevention

There was a range of up-to-date health promotion literature available in the waiting area with information about physical and mental health and lifestyle choices. For example, there was information available on diet, smoking cessation, alcohol consumption and sexually transmitted infections. This information was supported by extensive pages on the practice web-site about various health promotion and ill-health prevention topics such as diet, smoking, vaccination, travel, contraception, mental health and keeping fit. There was also a dedicated web page containing links to national and local support groups or networks for a range of conditions and health related issues.

All new patients completed a general health questionnaire with information about their medical history and their lifestyle choices, such as whether they smoked or took exercise and how much alcohol they consumed. When patients first registered they were invited into the surgery to see a nurse or healthcare assistant for a health check and exploration of their medical history and lifestyle. All patients over 40, including those over 75, received a NHS health check by the nurses that had been trained to carry this out.

We saw that there was a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing; for example, by discussing chlamydia screening with patients aged 18-25 years or offering advice to smokers. We saw that GPs also used a predictive tool during assessments to help identify patients who were at higher risk of cardio-vascular disease.

The practice held a weekly smoking cessation sessions run by a visiting adviser and also a weekly counselling service. Double appointments were available with GPs for patients receiving chronic disease consultations and nationally collected data showed that outcomes were generally favourable for such patients. For example, we saw that some outcomes for patients with diabetes were significantly better than the rest of England or the CCG area. This included data that showed a higher percentage of patients with diabetes had had their blood pressure monitored and a higher percentage of had a record of retinal screening to assess for one of the neuropathic risks

Good

Are services effective?

(for example, treatment is effective)

associated with the condition. As reported above, data also showed a high prevalence of coronary heart disease but with a lower prevalence of heart failure and a significantly lower prevalence of emergency admissions for these patients.

National data showed that the practice was similar to expected in comparison to the CCG and the rest of England for some other preventative aspects of the service it provided. This included cervical screening, childhood immunisations, provision of the flu vaccine to older people and other patients at risk and physical health monitoring of patients with mental ill-health.

Our most significant findings related to the practice's work towards reducing the number of emergency admissions to hospital through the use of additional GP appointments using the winter pressure initiative reported under 'Responsive' below.

Outstanding ☆

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. We spoke with five patients on the day of our inspection. All of the patients we spoke with reported that their GP and the nurses were courteous, considerate and compassionate. Patients told us that all the reception staff were polite and had a pleasant manner. This was borne out during our observations in the reception area when we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the desk. For example, we noted that patients were spoken with in discreet, low tones which minimised the risk of being overheard. There was also a notice in the reception area advising patients that they could speak in private with a receptionist if they wished. Staff confirmed that patients were sometimes taken to another room if patients requested this. The reception area was in a separate room to the main waiting area and this also ensured that conversations were not overheard.

We looked at data from the National Patient Survey reported in January 2015, carried out for the NHS. All of the data reflecting patients' views of the practice was commonly higher than, or significantly higher than, the averages for the Clinical Commissioning Group (CCG) area and for England in general. For example;

- 94% or patients stated they would recommend the practice. This was significantly higher than the rest of the CCG area (82%) and among the best ratings as compared with the rest of England (78%).
- 94% of patients stated that their overall experience of the practice was good or very good; this rating, too, was higher than the CCG average (87%) and among the highest range of ratings nationally where the average was 85%.

We saw there had been four reviews posted on the NHS Choices web-site in the year leading up to our inspection. One of these was praiseworthy in relation to the staff been helpful and caring. Three further anonymous reviews reported negative experiences of the helpfulness of reception staff. In its responses to those reviews, the practice had made attempts to contact the reviewers to ascertain further details with a view to taking action to correct any shortcomings. However, these reviews did not reflect the findings of the National Patient Survey, the views of patients we spoke with during our inspection or the views expressed on the 27 comment cards collected from patients in advance of our visit. For example, the survey showed that 92% of patients reported that the reception staff were helpful, higher than the CCG average (88%) and the rest of England (87%). None of the comment cards indicated any negative opinions and all of the cards reported wholly positive experiences. Some comments were overwhelmingly positive, referring to doctors and staff by name and singling out individual examples of kindness, care and compassion.

A common theme among patients' views expressed on the comment cards was that patients felt they were listened to by the GPs and the nurses. This was supported by the National Patient Survey which showed that 96% of patients said the GP was good at listening to them compared to the CCG average of 90% and the England average of 89%. 94% felt that the nurses listened to and were attentive to their needs as compared to the CCG and England average, both at 91%.

We saw that there was a notice in the reception area that displayed the practice's 'mission statement'. This notice stressed the importance of care centred on patients' needs provided by caring and empathetic staff. A reception staff member and a nurse we spoke with talked about this mission statement and of their commitment to providing a caring and compassionate service. Additionally, we saw that the practice had supported a caring, patient-centred approach for vulnerable families by appointing one of the administrative team as a vulnerable families' champion. We have reported on this above under 'Safe'.

Further evidence from the National Patient Survey showed that this practice had a caring and patient-focused culture. For example;

- 95% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.96% of patients felt the nurses gave them enough time compared with 92% of patients in the CCG area and nationally.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%. 99% said they had confidence and trust in the nurses as opposed to 98% and 97% for the CCG and England respectively.

Are services caring?

- 95% of patients said that the GP was good at giving them enough time compared to 87% for both the CCG area and for England. 96% said the nurses were good at giving them enough time compared with 92% in the CCG and England.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Nursing staff were primarily used as a chaperone. If nursing staff were not available to act as a chaperone receptionists undertook this role and we saw that they had received training and had undertaken criminal records checks to ensure they could carry out this role. Female patients we spoke with confirmed that they had been offered a chaperone but none said they had felt the need to use one. In addition, all treatment and consulting rooms were closed during consultations and we saw that they were equipped with curtains to further preserve patients' dignity during physical examinations.

Staff told us they followed the practice's confidentiality policy and understood the risks inherent in handling information about patients. We noted that all staff observed a clear desk policy throughout the day.

We noted that a zero tolerance policy was posted in the reception area about situations involving potentially aggressive patients. Staff we spoke with said they understood this policy and were reassured by it although the instances of them feeling uncomfortable as a result of patients' behaviour were very rare.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. Our interviews with patients during our inspection showed that they were very pleased with their level of involvement. Some patients we asked told us they felt in control of their health care. All patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions.

This was supported by the National Patient Survey. This showed that, 95% of patients felt the GP was good at explaining tests and treatments to them compared with 87% for the CCG area and 86% for the rest of England. This figure was 98% for the nurses, higher than the CCG and England average of 90%.

The survey showed that 89% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were higher than the average for both the CCG area (81%) and for England (82%). The corresponding figure for the nursing staff was also higher, at 90%, than the CCG average (84%) and England (85%).

We found that patients who were referred onwards to hospital or other services were involved in the process. We saw that patients could make a choice about where and when to receive follow-up treatment from hospital providers by the use of the 'choose and book' system. GPs told us they completed referral notes in the presence of patients so that they understood and were part of the process. Patients we spoke with confirmed that this was the case.

The practice had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment and double length appointments were available for this purpose. As the patient population was predominantly English speaking, such instances were very rare with only two to three occasions during each year.

Patient/carer support to cope emotionally with care and treatment

The National Patient Survey showed a 94% satisfaction rate for patients who thought they were treated with care and concern by their GP. This was higher than the CCG and the national average which were both at 85%. The satisfaction rates for patients who were treated with care and concern by the nursing staff were at 95% compared with 91% for the CCG area and 90% nationally. These satisfaction rates supported the prevailing view of the patients we spoke with on the day and the views expressed on comment cards.

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, particularly those that were recently bereaved. For example, staff were alerted to the names of the patients who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support.

Outstanding ☆

Are services caring?

In any event, GPs called bereaved relatives to establish how they were and to determine if any extra support was required. Support was then co-ordinated by a member of staff designated as a bereavement champion. Such support included, for example, bereavement counselling provided by a specialist service nearby to whom patients could be referred if required.

Patients identified as carers were provided with information about local carer support services and referrals to these services were actively managed by a designated 'carer's champion'. All carers were identified on the practice records system so that their needs could be taken account of during consultations. Carers were also offered physical health checks. The practice also enabled an independent service to run a counselling clinic at the practice every week and patients were referred directly to this service by the GPs.

As reported in 'Safe' above, the practice had designated a staff member as a vulnerable families champion who was responsible for following up any missed appointments by any children, whether or not they had been identified as being vulnerable or at risk. The staff member also liaised with the health visitor on a regular basis to ensure vulnerable children were highlighted.

The care plans of patients who were receiving end-of-life care were also discussed at bi-monthly multi-disciplinary team meetings that involved the Macmillan service. This ensured that the practice could regularly and actively monitor the evolving health and support needs of this group of patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. The practice made use of an alert system on the patient records system to help them to identify patients who might be vulnerable or have specific needs This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care or those who were recently bereaved.

One of the GPs was the chair of the Hertsmere locality group of the clinical commissioning group (CCG). This ensured the practice was in a unique position to understand the needs of the local area and the services offered by other practices. Moreover, the practice's use of benchmarking information and their standing within the area ensured they were in a position to influence and shape primary care in the area for good outcomes for patients. This is illustrated in the practice's approach to reducing emergency hospital admissions set out below.

The practice had carried out a demand audit during the autumn and winter months of the 2011 to 2012 financial year in order to assess whether additional GP appointments would be required to sustain the level of service. As a result of this audit, for the winter months (November to March) of the next two financial years, the practice deployed an additional, long-term locum GP. Thereafter, this initiative attracted winter pressure funding from the CCG for the winter months of 2014 to 2015.

The practice had produced a business case to the CCG to support the implementation of this initiative in its locality area. This enabled the practice to increase their GP appointment capacity by around 20% during the five month periods for each of these years so that vulnerable patients who were at greater risk of hospital admissions had access to a GP at a time when demand was at its highest.

Furthermore, the practice's success in this area meant that it was influential in ensuring this scheme was subsequently adopted across the three other locality areas of the CCG at different times throughout the winter months. The practice produced graphical information and benchmarking data to us from across the CCG that showed how the additional appointments bore a relationship to reduced hospital admissions for the practice, the locality and the CCG. That is, a fall-off of such admissions was noted during the periods the initiative was operating, with the fall-off occurring at a time during this period that coincided with the time that the localities had adopted the scheme.

Tackle inequity and promote equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, in addition to patients with long term conditions, the practice held registers for particular groups of patients that received regular or scheduled treatment in accordance with the practice's contractual arrangements. In this way, patients with learning disabilities, patients with dementia and those with poor mental health were identified and so that their physical health needs could be monitored alongside their psychological well-being. Longer appointments were available for these groups of patients to enable their consultations to be more effective.

The practice had both male and female GPs and patients could choose which GP to see.

The practice was in an older, converted house. However, there was a ramp access to the practice for patients with wheelchairs or pushchairs and a doorbell for patients to ring for assistance if they had a disability inhibiting them from gaining access. Two GPs occupied upper level consulting rooms. Patients who could not manage the stairs were offered appointments on the ground floor with their chosen GP.

Although the practice had access to an interpreting service, there was a limited requirement for them. This was because the practice's population was almost exclusively English speaking. Nonetheless longer appointments were available for patients who required translation facilities and for those who had difficulty getting in and out of surgery quickly. Longer appointments were also available for patients who had complex needs. The practice web-site also had a translation facility.

The practice had a small number of registered patients who lived in a well-established local traveller's site and the practice ensured that this group of patients had equal access to the range of its services. For example, the staff member designated as vulnerable families champion ensured that families were called in for childhood

Good

Are services responsive to people's needs?

(for example, to feedback?)

immunisations and that any missed appointments were followed up. Patients who did not ordinarily reside in the area could see a GP on the basis of their treatment being immediately necessary.

The practice had up-to-date polices on bullying, harassment and discrimination that were accessible to staff on the practice intranet along with all the other practice policies. The practice also had an equality and diversity policy that it had distributed to staff along with a quiz to enable them to self-test their knowledge. We saw that equality training had been scheduled to take place in the month following our inspection.

Access to the service

The practice is located in an area which has a higher than average proportion of working age women between 40 and 49 years and a higher than average population of men and women over 65 years. The practice was open every day between 8am and 6.30pm and had an additional early morning session every Monday and Wednesday between 7am and 8am to enable patients who travelled to work to see their GP. This included an early morning phlebotomy service for patients providing fasting blood samples. There were no late evening extended hours. As previously reported, longer appointments were available for patients with more complex needs or for patients with a learning disability, poor mental health or dementia.

Some appointments were released for booking up to one week in advance, with a limited number of further appointments being released up to two days in advance. Half of the appointments were made available on the day. Patients who wished to be seen in an emergency were offered an appointment slot after 2pm when more appointments were made available for that purpose. A scheduled number of telephone consultations were also available to patients at the end of morning surgery hours where a GP would make a decision as to whether the patient needed to come in to be seen or treated through telephone advice.

Patients who were too ill to come to the surgery or who were housebound were offered home visits and these were booked over the telephone from 8.30am. Out of practice opening times patients were directed to the out-of-hours provider, Herts Urgent Care.

Patients could book appointments over the telephone, in person or by registering to use an online facility governed by the practice's electronic patient record system. During busy times additional staff answered the telephones to ensure patients did not have to wait longer than necessary for their call to be answered. The 2015 National Patient Survey showed that only 66% of patients found it easy to get through to the practice on the telephone. The practice acknowledged that the telephone system was in need of an upgrade to ensure patients could get through more effectively in the mornings. We saw that they had sought additional, improvement grant funding to enable this upgrade to take place which would include the addition of a dedicated line for patients over 75 years, a line for parents of children worried about the children under five years and another line for those who might have fallen and were in need of assistance. This new system had not yet been installed at the time of our inspection.

Other data from the National Patient Survey indicated that the practice was performing as expected in relation to patients' experiences of making an appointment. For example:

The practice served the needs of patients living in four local care homes and patients could be seen when required. One of the care homes received a ward round by one of the GPs once every week.

- 80% were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 93% said they were able to get an appointment to see or speak to someone the last time they tried as compared to 89% for the CCG and 85% nationally.
- 71% described their experience of making an appointment as good compared to the CCG average of 7% and national average of 73%.

Having made an appointment and arrived at the practice, patients' experiences were significantly better, with 90% saying they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.

Listening to and learning from concerns and complaints

The practice listened to concerns and responded to complaints to improve the quality of care. The practice had a system for handling complaints and concerns according to their policy that was in line with recognised guidance and contractual obligations for GPs in England. The

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice manager was the designated responsible person who handled all complaints. There was a complaints information leaflet on the practice web-site and in the waiting area. A complaints, compliments and comments form was also available that could be completed online. The five patients we spoke with on the day of our inspection told us they knew how to make a complaint but said they had never had cause to do so.

We looked at several examples of complaints that affected patients where the patient concerned had been given an apology and had been informed of actions the practice had taken to learn from the incident.

We also saw that the practice learned from complaints and comments and that discussion about these was a standing agenda item at the fortnightly clinical meetings alongside significant events. Similarly, the practice disseminated learning from complaints and feedback to staff at monthly protected time events. One of the outcomes of such discussions about patient feedback was the introduction of telephone consultations which the practice had implemented at the beginning of the year.

The practice took note of feedback from the National Patient Survey as part of their data monitoring and improvement activity. The practice was working to a patient survey action plan in which three areas for improvement had been identified. For example, the practice had responded to feedback about the difficulty in telephone access by submitting an improvement grant funding bid to upgrade the telephone system.

The practice scrutinised information received through the Friends and Families Test which they collated monthly. The practice also responded to some adverse anonymous comments on the NHS Choices web-site about unhelpful reception staff. Patients we spoke with and the comments cards we received indicated a positive experience of the reception staff. The National Patient Survey indicated that 92% of patients thought the reception staff were helpful, compared to 89% for the CCG and 87% for the rest of England. Nonetheless, the practice had shared the NHS Choices feedback with the reception staff and asked them to consider how they could ensure they maintained their reputation as a patient-friendly practice.

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 GPs told us that they believed everyone should have access to high quality, safe care, tailored to meet their individual needs. This was a vision that was reflected in the practice's mission statement, which emphasised patient-centred care for every patient. This was posted on the wall in both the waiting room and the staff room. Staff we spoke with confirmed that they had been consulted on and had helped to shape the practice mission statement, saying it had led to a happy and involved workforce who all shared this vision of providing good care.

The practice's emphasis on patient-centred care and safety set out in their mission statement and reinforced by the staff commitment to providing a caring and compassionate service showed that the practice had created an exemplary caring culture. This was clearly demonstrated by data from the National Patient Survey, patient interviews and views expressed on comment cards reported in 'Caring' above.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that they were operating safely and effectively. There were clearly identified lead clinical roles for areas such as, diabetes, respiratory conditions, cardio-vascular conditions and safeguarding. The practice had identified a lead nursing staff member for other areas of business such as infection control and women's health. There were also clearly defined 'champion' roles carried out by members of the administration team, such vulnerable families, carers and bereavement champions.

In addition, one of the GPs chaired the Hertsmere locality group within the CCG area, whilst another participated in a medication group. This ensured the practice benefitted from having senior practitioners who were leading on or instrumental in key local initiatives.

The practice used a number of processes to monitor quality, performance and risks in a holistic, integrated way that we have described under 'Effective' above. This included data benchmarking, reflective practice, significant event analysis (SEA), clinical audits, learning from SEA and complaints with all activity directed by the fortnightly clinical meetings at which all of the GPs and nurses were present. Oversight of the practice was maintained by a monthly business meeting which involved just the partners and the practice manager. All other staff were involved by way of monthly protected time meetings where staff were updated on key issues and were given the opportunity to provide feedback. Decision making and communication across the workforce was structured around these key, scheduled meetings

There were clear policies for each aspect of the practice's business accessible to staff through the practice computer system and these were subject of periodic review to ensure they were up-to-date. Staff were made aware of key policies during induction and could get access to clear instructions or protocols that set out how their work was to be performed. This included a comprehensive business continuity plan aligned to specific risk assessments that enabled the practice to continue to operate in the event of an emergency.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice vision of putting patients first. The GPs and the practice manager were open, highly visible and approachable. As well as the clear formal meeting structure the practice operated an inclusive approach to staff involvement and decision making, which encouraged staff to contribute their views. For example, information about the practice's performance was shared with staff, such as data from the QOF, the findings of audits and results from patient surveys. This ensured staff had an interest in the success of the practice and in delivering the practice vision.

We spoke with staff about this approach and they told us they felt valued and able to contribute. Staff were positive in their attitudes and presented as a happy workforce. We felt this to be evidence of the effectiveness of the open and candid approach adopted by the practice.

There were robust policies in place that also had the practical effect of supporting staff. For example, we noted that there was a zero tolerance policy in place in relation to abuse or violence towards staff and this was overtly publicised in the practice and on the web-site. This demonstrated that staff safety and wellbeing was treated as a priority by the practice.

As well as a visible leadership style within the practice, the GPs were highly visible within the CCG and the locality.

We saw that the practice had succession plans in place to ensure continuity of leadership with a person already in

Are services well-led?

Good

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

post receiving a handover from a member of the leadership team who was in the process of retiring, and plans to do similar within the next three years for another key member of the team.

Seeking and acting on feedback from patients, public and staff

The practice did not have an active patient participation group (PPG), a group made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. We learned that, until 2013 the practice had had an active PPG but at the time of our inspection it was no longer in existence. The practice manager explained that this had been due to an inability to recruit younger members to the group to better reflect the practice's population and so interest in the group from its membership had gradually decreased.

The practice had run several recruitment campaigns to try and re-introduce the PPG through advertising but these had been unsuccessful. The practice manager explained that they had identified a number of people who had expressed an interest and that this group would be reinvigorated. At the time of our inspection the practice was once more actively making attempts to re-form a PPG with information on the web-site and in the practice waiting area.

Although there was no PPG in place, the practice still actively sought feedback from patients, such as the dedicated section of their web-site that asked patients to submit comments, complaints or compliments and the suggestions box in reception. We saw that the practice acted on patient feedback; for example, the previously reported implementation of telephone consultations as a result of patient feedback.

The practice had also implemented the Friends and Family test with a prominent display in the reception area requesting feedback by way of questionnaire. The most recently available Friends and Family data from January 2015 showed 28 positive comments out of 29 that had been received.

The practice had analysed the findings of the latest patient survey from January 2015 and had derived an action plan from it in order to manage improvements identified by the feedback. For example, one of the actions was designed to address the feedback about the ease of telephone access and involved an improvement grant funding bid to upgrade the telephone system.

Management lead through learning & improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for learning through protected learning time and clinical supervision.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. We have already reported that the practice was outstanding in its approach to quality monitoring and improvement as evidenced by patient outcomes.

Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working. The appointment of designated staff to lead, or 'champion' roles showed that the practice valued the contribution of its staff and the improvements to patient care arising from the learning this would bring. It was clear to us that everyone who worked at the practice found the leadership style to be of great benefit and helped them to develop a learning culture. This showed that the practice had a dynamic and responsive approach to seeking opportunities to learn and improve.