Schopwick 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Schopwick Surgery on 19 December 2016. Overall the practice is rated as outstanding.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed and the practice sought to continually improve processes.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had invested significant resources into improving and expanding access. This included the provision of extended opening times and an innovative virtual surgery.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- Clinical staff proactively shared decision making with patients. This meant patients had input into their condition management plans as a strategy to help empower them to improve their health.
- There was a consistent, overarching focus on health promotion and educating patients to live healthier lives as part of a collaborative relationship. A dedicated carers' champion and resource centre, and bi-annual healthy living events helped to embed this in practice and there was evidence of improved patient outcomes as a result.

Summary of findings

- The practice was proactive in providing palliative care and support for patients in line with the national Gold Standards Framework. This was one example of a substantial range of multidisciplinary relationships and initiatives that the practice proactively sought to develop to meet the needs of its patients.
- There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.
- An innovation lead GP was in post who provided support to staff to improve patient care and reduce health inequalities in the local population. Recent innovations had been rewarded and recognised by national bodies, which was indicative of the commitment and passion of the practice team.

We found areas of outstanding practice:

- A GP acted as the dedicated lead for IT development and patient engagement through social media. The virtual surgery provided patients with direct access to health advice and guidance and enabled them to get a fast response from a GP for non-urgent conditions.
- The practice had been recognised nationally for its innovative work in supporting carers and in developing a community navigators programme. This led to the practice staff being awarded a Health Service Journal Value in Health Care Award in 2015. In addition, the housebound project was recognised by the Royal College of General Practitioners (RCGP) and staff were selected to present their work at the annual conference in 2016.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared internally and with external colleagues to make sure action was taken to improve safety and reduce the risk of a repeat incident.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. This included multidisciplinary risk assessments and protocols that enabled staff to respond quickly to patients at risk.
- Medicines management processes were in place including repeat prescription monitoring, emergency drugs checking and a safety alerts protocol.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were significantly better than national and local averages in three areas of clinical care and comparable to national and local averages in other areas.
- Staff assessed needs and delivered care in line with current evidence based guidance and used a weekly review system to ensure they were always to date with latest standards.
- Clinical audits and benchmarking exercises demonstrated quality monitoring and improvement. The practice had a demonstrable track record in identifying areas of good practice in patient care, opportunities for multidisciplinary working and area for improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. This was because there was a consistent, embedded culture of promoting professional development through extended clinical training.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff that demonstrated the commitment of the senior team to building on the skills and interests of each individual.
- Multidisciplinary working was used proactively to improve patient outcomes. Staff had established substantive links and relationships with a range of secondary care, community and non-profit providers to ensure patients received holistic, consistent and specialised care.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Feedback from patient surveys and CQC comment cards indicated patients were treated with compassion, dignity and respect.
- The practice actively encouraged patients to be involved in decisions about their care and worked with 'expert patients' to ensure care planning met their needs and expectations.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient confidentiality.
- Structured emotional support was in place for patients including in-house access to counsellors and a bereavement service.
- A dedicated carers champion provided access to psychological support for carers, including after a bereavement.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

- Practice staff readily engaged with the Clinical Commissioning Group (CCG) to provide extended and responsive services to meet people's needs. This included through the adoption of the standards of the national Gold Standard Framework for palliative care, the development of an innovative housebound care protocol and a range of services for carers. The practice and its team held lead roles in the local area in relation to dementia and home care.
- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility, choice and

Summary of findings

continuity of care. This included flexible and urgent appointments and significant proactive work to ensure patients with complex needs had access to rapid, specialist care and support.

- The involvement of other organisations and the local community was embedded in service planning and ensured the practice met people's needs. This included the development and implementation of innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- There was a significant track record of responding to individual and complex needs, including when they were outside of the immediate jurisdiction of the practice. This included intervention to help a homeless patient access vital services such as a food bank and housing.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances.
- The practice had improved access through the development of an innovative virtual surgery portal and extended hours that included early mornings, evenings and weekend clinics. Staff proactively engaged specialists to provide in-house clinics, including a community navigator, physiotherapist and counsellors. Additional services were provided in response to the needs of the population such as a monthly hearing aid maintenance service
- There was active review of complaints by two complaints managers and improvements were made as a result across the services. Patients were involved in the review of their complaint.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led.

- Leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.
- There was an innovation lead in post and the practice demonstrated the impact of innovative pilot projects through their achievement of the Health Service Journal Value in Health Care Award in 2016 for work in supporting carers and developing a community navigator role.

Summary of findings

- The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. This included adopting innovative protocols and processes for quality improvement and readily accepting the challenge of pilot programmes.
- The practice prioritised reducing health inequalities in the local community and adopted a systematic approach to working with other organisations to improve care outcomes.
- Governance and performance management arrangements were proactively reviewed and GP trainees were involved in these as part of their ongoing development.
- Leaders demonstrated an inspiring shared purpose, drive to deliver and motivated staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture, which was evidenced through feedback from staff.
- There were high levels of staff satisfaction. Staff were clearly proud of the organisation as a place to work and spoke highly of the culture. There was consistently high levels of constructive engagement with staff.
- There was demonstrable collaboration and support across all functions and a common focus on improving quality of care and patients' experiences, achieved through feedback, meeting events and audits.
- The leadership team promoted continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated, such as in the development of a mobile phone app to assess cancer risk by a GP trainee. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care by reviewing successful models outside of the local area.

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 good for the safe, effective and caring domains and outstanding for responsive and well-led. The practice overall is rated outstanding, which includes services for this population group:

- The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice had been recognised by the Royal College of General Practitioners for its work in developing a housebound patient visiting service.
- A carers' champion was in post who provided a single point of access for advice and same-day appointments. This service had been recognised with a Health Service Journal Value in Health Award in 2016.
- The practice was responsive to the needs of older people, and offered home visits, urgent appointments and extended appointments.
- Two GPs and a receptionist provided dedicated support to local nursing homes that included same-day appointments and continuity of care.
- The practice facilitated multidisciplinary palliative care that included advance care planning in line with the national Gold Standard Framework.

People with long term conditions

Outstanding ☆

The practice is rated as good for the safe, effective and caring domains and outstanding for responsive and well-led. The practice overall is rated outstanding, which includes services for this population group:

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. A GP partner was the clinical lead for patients with long-term conditions and maintained a register of patients that ensured patients received continuity of care.
- Staff used templates and registers to provide timely and structured care, including proactive reviews.
- The practice performed significantly better than national and Clinical Commissioning Group averages in the Quality Outcomes Framework in three clinical domains relating to long term conditions.

Summary of findings

- Longer appointments and home visits were provided for patients along with a range of extra services, including a virtual clinic that offered advice and guidance on condition management.
- Patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding ☆

The practice is rated as good for the safe, effective and caring domains and outstanding for responsive and well-led. The practice overall is rated outstanding, which includes services for this population group:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. This included children and young people who had a high number of emergency hospital attendances and those who were known to be affected by health inequalities.
- Immunisation rates were similar to national and Clinical Commissioning Group averages for standard childhood immunisations.
- Children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. This included new mother and baby focused reviews and targeted meetings with foster carers and looked after children.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.
- The practice proactively encouraged family registrations to ensure holistic care.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as good for the safe, effective and caring domains and outstanding for responsive and well-led. The practice overall is rated outstanding, which includes services for this population group:

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted

Summary of findings

the services it offered to ensure these were accessible, flexible and offered continuity of care. This included a range of extended hours, a virtual clinic access and the flexibility to be seen in either of the available practices.
- The practice was proactive in offering a full range of health promotion and screening that reflected the needs for this age group. This included screening for prediabetes, atrial fibrillation and chlamydia.
- A travel vaccination service and 'catch-up' vaccination service was offered.
- This population group were targeted with a bi-annual healthy living event that provided patients with access to specialist health organisations.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as good for the safe, effective and caring domains and outstanding for responsive and well-led. The practice overall is rated outstanding, which includes services for this population group:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- A lead GP for learning disabilities was in post and provided annual reviews, safeguarding reviews and health checks.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients, including independent advocates.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.
- Regular carers clinics were offered that enabled carers to meet each other and receive guidance and support from staff as a group.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as good for the safe, effective and caring domains and outstanding for responsive and well-led. The practice overall is rated outstanding, which includes services for this population group:

Summary of findings

- The practice was the lead organisation in the Clinical Commissioning Group for mental health and dementia.
- 86% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was better than the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- Each patient had a structured annual mental health review and Lithium monitoring.
- The practice carried out advance care planning for patients with dementia.
- The practice supported patients experiencing poor mental health to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia, such as through the use of a dedicated patient resource room for patient support meetings.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016 and relate to responses between July 2015 to September 2015 and January 2016 to March 2016.The results showed the practice was performing in line with local and national averages. 288 survey forms were distributed and 120 were returned. This represented 42% of the practice's patient list.

- 63% of patients found it easy to get through to this practice by phone compared to the Clinical Commissioning Group (CCG) average of 78% and the national average of 73%. The practice had put in place additional phone lines and a new morning triage system to address this.
- 80% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 79% and the national average of 76%.
- 92% of patients described the overall experience of this GP practice as good compared to the CCG average of 89% and the national average of 85%.
- 90% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 85% and the national average of 80%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 38 comment cards, which were all positive about the standard of care received. Nine patients commented on the ease of accessing the service when they needed to, including in an emergency. Ten patients noted they felt they received continuity of care in the management of long-terms conditions and more than 75% of respondents described staff as helpful and friendly.

Outstanding practice

- A GP acted as the dedicated lead for IT development and patient engagement through social media. The virtual surgery provided patients with direct access to health advice and guidance and enabled them to get a fast response from a GP for non-urgent conditions.
- The practice had been recognised nationally for its innovative work in supporting carers and in developing a community navigators programme. This led to the practice and clinical commissioning group being awarded a Health Service Journal Value in Health Care Award in 2015. In addition, the housebound project was recognised by the Royal College of General Practitioners (RCGP) and staff were selected to present their work at the annual conference in 2016.

Schopwick Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector supported by a GP specialist adviser

Background to Schopwick Surgery

Schopwick Surgery is a two-site GP service. Services are provided from the following main location and the branch practice. Patients can attend either of the two locations. We visited the main practice during this inspection:

Schopwick Surgery (the main practice)

Everett Court

Romeland

Borehamwood

Hertfordshire

WD6 3BJ

Bushey Practice (the branch practice)

Windmill Street

Bushey

WD23 1NB

It has a clinical team of eight GP partners, three GP registrars and one salaried GP. This includes seven female GPs and five male GPs. Three practice nurses and a healthcare assistant are available and a team of 17 receptionists and eight administrators provide non-clinical support.

The practice is readily accessible for people who use wheelchairs and by parents with pushchairs. A portable hearing loop system is available and there are quiet waiting facilities for patients who find the main waiting area can cause anxiety. Private space is available for breast-feeding.

The practice services a patient list of 12,878 and is in an area of very low deprivation. Of the patient list, 48% are living with a long-term condition and 58% are in paid employment or full time education.

This is a teaching and training practice, including for foundation level and specialty trainee doctors, medical students from two universities and student nurses.

Appointments are from 8.30am to 6.30pm Monday to Friday. Saturday morning appointments are available on alternate weeks and the service offers Sunday flu clinics. The practice offers commuter appointments from 7am on demand and after-school appointments from 6.30pm to 8pm two evenings per week.

We previously carried out an inspection in August 2013, when we judged the practice as 'compliant' according to our inspection criteria at the time.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 December 2016.

During our visit we:

- Spoke with a range of staff from the clinical and non-clinical teams.
- Observed how patients were being cared for and reviewed feedback provided from CQC comment cards.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed audits and documentation relating to safety and quality assurance.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Ten significant events (SEs) were reported in the practice between March 2016 and December 2016.
- Three teams in the practice investigated significant events (SEs) depending on the nature of the incident. For example, the practice manager led SE investigations that applied to the non-clinical team, an SE lead GP led investigations for incidents related to doctors and the nurse lead led SE investigations for nursing staff. The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- All staff attended a three-monthly SE review meeting to discuss the progress of investigations and learning outcomes. Ad-hoc meetings were convened in urgent cases.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following a prescription error, new medicines management and safety processes were implemented to ensure patients always received the correct medicine at the correct dose.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Two GPs were joint-leads for safeguarding adults and children and there was always safeguarding lead availability when the practice was open.
- Clinical staff had training in recognising and responding to female genital mutilation and we saw this was effective in protecting patients they believed to be at risk.
- GPs led dedicated multi-professional adult and child safeguarding meetings and provided regular in-house training for all staff, including case studies and scenarios. Multi-disciplinary community staff took part in the training to ensure continuity of care for patients. Staff used the patient records system to flag individuals known to be vulnerable and they were offered flexible appointments.
- The GPs attended safeguarding meetings and provided reports for other agencies. This included in urgent complex cases, such as when a parent disclosed recreational drug use. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three and met with health visitors every two months. We saw meetings with health visitors were minuted and a designated member of staff ensured actions and follow-ups were completed consistently and in a timely way.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The lead practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

Good

Are services safe?

- The arrangements for managing medicines, including emergency medicines and vaccines, kept patients safe. This included obtaining, prescribing, recording, handling, storing, security and disposal of medicines. The practice had two fridges for vaccines and chilled medicine and both had digital temperature monitoring devices. The lead nurse monitored temperature recording of the fridges to ensure they maintained a temperature within medicine manufacturers' safe guidelines.
- A repeat prescribing protocol ensured high risk medicines were reviewed regularly in line with National Institute of Health and Care Excellence guidance.
- The practice carried out regular medicines audits, with the support of CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The healthcare assistant was trained to administer vaccines and medicines against a Patient Specific Direction prescription or direction from a prescriber.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. This included proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and a designated health and safety lead was in post. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure both surgeries were full staffed.
- Medicines management processes ensured risks to patients were monitored and addressed. For example, uncollected prescriptions were reviewed every two months and the duty doctor called each patient individually to discuss this. Where the patient was known to have safeguarding needs or mental health needs, a GP followed up with them more regularly.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available on-site and in two emergency grab bags. The grab bags could be used for clinical staff to respond to emergency situations in and around the practice.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available. The lead nurse documented weekly safety checks to emergency equipment.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were kept at the main surgery and the branch practice. All of the staff we spoke with demonstrated detailed knowledge of their actions and responsibilities in a major event.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. This included a weekly meeting to review changes to guidance from NICE and medicine alerts and recalls issued by the Medicines and Healthcare Products Regulatory Agency.
- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. This was available electronically and hard copies of commonly used NICE guidance were provided in each treatment room for rapid access.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Staff used national best practice guidance to ensure projects and audits were benchmarked against national standards. For example, the housebound project had been developed in line with Royal College of General Practitioners guidance for housebound patients and was provided within a structured protocol. This included a weekly at home visiting service and an annual one hour consultation for each patient in their own home.
- Projects and pilot schemes were developed using a structured approach that enabled staff to identify the needs of patients and modify programmes accordingly. For example, the housebound project followed a four-stage piloting and developmental cycle that included scoping home visits and looking at patient outcomes to ensure the new service could meet patients' needs effectively.
- We looked at a sample of nine care plans for patients who were treated for long term conditions. We found they were comprehensive, up to date and demonstrated individualised care. For example, a patient with heart failure was prescribed anticipatory medicine and there was documented evidence of a discussion between clinical staff, the patient and their family.
- The virtual clinic, offered online, included patient-led risk assessments to enable GPs to diagnose and refer patients more efficiently. Patients had access to five questionnaires to facilitate this, including the Oxford Knee Score, Oxford Hip Score, Epworth Sleepiness Scale and assessments for contraception and urine symptoms.
- The practice was proactive in screening patients for specific risks and this led to structured support plans. For example, the practice identified patients who may be at risk of prediabetes. Patients were invited to a consultation with a practice nurse for lifestyle advice and offered an annual blood glucose test. In addition, the practice had screened all registered patients with a protocol to identify elevated risk of atrial fibrillation. Each patient at risk was invited to a clinical review and as a result received care that helped protect them from stroke. As a result of the exercise the practice had doubled their prevalence of patients with known atrial fibrillation, which was 25% better than the national average.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results from 2015/16 showed that the practice had achieved 99.6% of the total number of points available.

Exception reporting was significantly higher (10% or higher difference) than the clinical commissioning group (CCG) or national averages in the osteoporosis domain. Exception reporting in this domain was at 30% compared to the CCG average of 12% and the national average of 13%. Exception reporting was significantly lower (10% or more better) than the CCG or national averages in the cancer, depression and primary prevention of cardiovascular disease clinical domains. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

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

- Performance for diabetes related indicators was similar to, or better than, the national average and CCG average

Good

Are services effective?

(for example, treatment is effective)

in all five indicators. For example, 99% of patients with diabetes received a flu vaccine in the preceding 12 months, compared to the CCG average of 96% and the national average of 94%. In addition, 90% of patients with diabetes had a foot examination and risk classification in the preceding 12 months, compared with the CCG average of 91% and the national average of 88%.

- Performance for mental health related indicators was better than the national average and the CCG average in all three indicators. For example, 94% of patients with schizophrenia, bipolar affective disorder or other psychoses had an agreed, documented care plan in the preceding 12 months compared with the CCG average of 92% and the national average of 88%.

There was evidence of quality improvement including clinical audit.

- There had been nine clinical audits completed in the previous 12 months, all of which were completed two-cycle audits where the improvements made were implemented and monitored.
- Audits were used to benchmark local practice against national best practice guidance, such as in the prescribing of Lithium and care of patients who had undergone a splenectomy. In this audit in 2015, it was found eight of 21 patients who were at risk of significant bacterial infection following a splenectomy did not have a prescription for prophylactic antibiotics and had not received a pneumovax in the previous five years. This meant these patients did not have the optimum, national standard of care. A GP contacted all of these patients to arrange a review and provide immunisations. The practice also provided individualised education and guidance on condition and risk management. The practice re-audited this patient group in 2016 and found 100% compliance with prophylactic antibiotics. In addition, 89% of patients had accepted the pneumovax vaccine. A GP contacted patients who had declined the immunisation individually to discuss their risk factors and options.
- In October 2016 a clinical nurse specialist in end of life care conducted a post-death audit of a sample of four patients. This assessed the practice's performance against key palliative care criteria including the use of a palliative care register, adherence to the Gold Standard Framework and the use of advance care planning. In all of these areas the audit showed the practice could evidence adherence to best practice. The audit also showed in two of the four cases reviewed bereavement support was offered and in three of the four cases, the patient's carer had their needs assessed.
- Staff used an annual audit cycle to monitor dermatology referrals against the two week wait cancer system. In 2016 the audit included 49 two week wait referrals, 10 of which resulted in the identification of a cancerous legion. Staff used the audit to ensure systems for identifying dermatological conditions met patient needs and referrals were appropriate.
- The practice improved prescribing systems and patient monitoring for people who needed warfarin as a result of an audit. For example, the audit found not all patients had undergone regular GP review and there were gaps in documentation from anticoagulation clinics. This meant in some cases patients did not receive the national gold standard of care. In response the practice engaged with every anticoagulation clinic used by patients to implement a standardised approach to documentation. Each patient who had not had a documented review in the previous 12 months was contacted and booked into a GP appointment.
- A GP audited prescribing of nitrofurantoin, a medicine used to treat urinary tract infections, against local prescribing guidance and safety guidance published in 2014. This measured prescribing against three key quality and safety standards such as the need to establish the patient's estimated glomerular filtration rate (eGFR), which refers to renal function. The first audit took place in 2015 and the re-audit took place in 2016. In both cycles the practice performed better than the local standards in the three safety criteria and recommendations made included a bi-annual check of patients eGFR for those prescribed nitrofurantoin on a long-term basis.
- In 2016 a GP audited patients who had an intrauterine device fitted to identify how many patients had these removed in subsequent months. The audit was also used to establish clinician's practice against guidance from the Faculty of Sexual and Reproductive Health. The audit identified 100% compliance with best practice. Three patients had their device removed within six months due to complications and patients received appropriate care and support.
- Patient outcomes were monitored to ensure they received the right follow-up care and treatment for their

needs. For example, the healthcare assistant contacted all elderly patients who had been discharged from hospital within three days. This meant patients who had experienced an unplanned hospital admission had follow-up care provided proactively.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment and there was a demonstrable track record of leadership in education, both in-house and in the community.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Initial and refresher training included safeguarding, fire safety awareness, basic life support and information governance.
- A GP partner was the lead for education and the practice had three GP trainers. The practice was part of a trainers' network, which had recognised the practice as providing a strong ethos of training and succession planning.
- Twice-weekly education and development sessions ensured staff had protected time for learning and were able to develop their professional skills in areas such as safeguarding, prescribing and caring for patients with complex needs.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months and the practice manager and GPs led these to ensure staff were reviewed and supported from both clinical and non-clinical leadership teams.
- Each GP partner was the lead for a specialist area of patient health or operation of the practice. This included areas such as a women's health lead, a lead for dementia and diabetes, a lead for learning disabilities and a housebound project lead. This meant patients with specific conditions or complex needs had access to a clinician with specialist training to support them.
- A locum induction pack was used to ensure locum doctors received a comprehensive introduction to the practice and had immediate access to electronic records and reporting systems.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. A daily duty arrangement was in place to ensure pathology results and other referral documents were reviewed and acted upon in a timely manner.
- The practice had adopted the Gosport Vanguard multidisciplinary access model and worked collaboratively as a result with community matrons, diabetic liaison nurses and mental health nurses to triage calls from patients and direct them to the most appropriate clinician.
- An electronic notification system was in place for patients who needed an urgent palliative care referral. We looked at examples of this in practice and saw it meant patients with urgent needs relating to end of life care received on-demand specialist input, care planning and pain relief.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were

Good

Are services effective?

(for example, treatment is effective)

referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. MCA training was provided in-house to the practice and multidisciplinary teams and MCA meetings were held on a responsive basis to meet the needs of individual patients.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. All clinical staff had training in the Gillick competencies and Fraser guidelines.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity using a four-step process and recorded the outcome of the assessment. The practice had guidelines on carrying out best interests assessments for patients with reduced mental capacity.
- The process for seeking consent was monitored through patient records audits and consent policies and documentation related to specific procedures. For example, verbal consent was obtained and documented for cryotherapy and immunisations and signed consent was obtained for joint injections, intra-uterine devices and other minor surgery procedures.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- There was a demonstrable focus on holistic patient health and a clear drive to empower patients with learning and knowledge. For example, the patient participation group helped to coordinate a bi-annual healthy living event that enabled patients and their families to meet specialists in health promotion and community service providers. The most recent event included 13 organisations including those specialising in cancer care, diabetes and weight management. Attendance was registered at over 300 people. Local police and fire services also attended to provide targeted advice and guidance for attendees.
- There was evidence the practice's focus on healthy living, health promotion and lifestyle advice resulted in improved health for patients. For example, from April 2015 to April 2016, 63% of patients who attended for a blood glucose monitoring visit, had an HbA1c (a measure of blood glucose) of below 59mmol/mol, which is a national recommendation. This was better than the CCG average of 58% and the national average of 60%.
- The practice provided patient education sessions on specific topics such as diabetes and asthma and a patient resource centre provided access to information on a range of health topics.
- In November 2016 the practice had provided a special health event for housebound patients and carers.
- Between April 2016 and December 2016, the practice performed similarly to or better than the CCG average for patient admissions to hospital emergency departments and non-elective hospital admissions for long term conditions. This meant fewer of the practice's patients attended hospital for urgent or emergency care, which reflected the ongoing approach to improving patient health education.

The practice's uptake for the cervical screening programme was 81%, which was similar to the CCG average of 83% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The uptake of breast cancer screening was 56% compared with a CCG average of 72% and national average of 73%. The uptake of bowel cancer screening was 49%, compared with a CCG and national averages of 58%. In response the practice had implemented proactive patient contact and health promotion strategies to encourage patients to screen.

Good

Are services effective?

(for example, treatment is effective)

There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to or better than CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 78% to 98%. Childhood immunisation rates for five year olds ranged from 86% to 96%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice proactively screened at-risk patients for specific conditions, including atrial fibrillation, pre-diabetes, retinal screening and physiotherapy needs. The practice also offered services for patients with long-term needs and conditions, such as maintenance checks on hearing aids, acupuncture and direct referrals to cognitive behavioural therapy.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 38 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with six members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

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

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received was positive and notes indicated patients felt they received individualised care. We saw that care plans were personalised.

Clinical staff proactively shared decision making with patients. This meant patients had input into condition management plans as a strategy to help empower them to improve their health. The practice also recognised expert patients and included them in discussions around their care planning.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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

- Translators were available to attend appointments with patients when staff had notice of their need. This was recorded on the electronic records system and meant reception staff could pre-emptively book language support. Where a patient attended an urgent

appointment or where staff were not previously aware of their need, a telephone interpretation service was available. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice offered in-house access to counsellors and therapists through the improving access to psychological therapies (IAPT) programme.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 204 patients as carers (1.6% of the practice list) and provided them with structured, proactive care and support. This was led by a dedicated carer's' champion who provided carers with direct access to advice and appointments. Written information was available to direct carers to the various avenues of support available to them and a carers' resource room was available at the Bushey surgery to provide people with a quiet space to talk and meet.

Staff used a structured bereavement protocol for patients and relatives. For example, if families had suffered bereavement, their usual GP contacted them with a sympathy card or letter. Where a registered carer suffered a bereavement, the carers champion called them personally with support and condolences.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered an on-demand commuter's clinic from 7am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were disabled facilities, a hearing loop and translation services available.
- A learning disability lead GP was in post and maintained a register of patients. At the time of our inspection this included 97 patients, of which 56% had received a full health check in the previous 12 months. We looked at examples of completed health checks and saw they were thorough and in line with Royal College of General Practitioners guidance and the Cardiff Health Check standard.
- The practice had fostered and implemented a carers' champion role to help support patients who were vulnerable or who had complex needs. This role had a demonstrable impact on the health and social outcomes of people. For example, the carers' champion helped one patient to access a specialist support group, secure housing and schedule an operation following a period of distress and homelessness. This involved significant effort and liaison with homeless support organisations as well as with a food bank to ensure the patient had access to hot meals. The carers' champion acted as a single point of contact for carers and provided access to same-day appointments as well as urgent referrals to crisis services, such as organisations providing emergency food parcels.
- Staff demonstrated a detailed awareness of the local population and implemented specialist roles to address their needs. For example, to address a significant number of patients with a learning disability, a GP partner established a lead role to provide continuity of care to each person. Two GP leads for patients who lived in nursing homes ensured patients had access to care when they needed it, including continuity of care from their named GP. This included access to home visits and appointments at short notice. To address the needs of a large housebound and frail population, a GP established a housebound project that ensured home visits could be provided at short notice with support from the CCG multidisciplinary team. This included a proactive care plan for each patient and a full health review at least annually.
- The practice was proactive in providing palliative care and support for patients. This included leading regular multidisciplinary gold standard planning meetings, providing anticipatory care plans and discussing do not attempt resuscitation decisions with the community palliative care team. A hospice at home team was available locally and practice staff liaised directly with them to help patients die in the location of their choice. This included direct support from the palliative care lead GP. We saw an example of clearly coordinated care between the palliative care lead and the hospice at home team that enabled a patient to die at home when their condition deteriorated rapidly.
- Staff had established a working relationship with a community care navigator from the CCG. This helped to ensure patients had access to adult social care and community services and the care navigator provided regular advice clinics in the practice.
- The practice had worked closely with a community navigator to ensure this service could be responsive to the needs of the practice's patients. The team had promoted the development of the service alongside the implementation of a carers champion. The navigator offered an on-demand advice and support service for patients who experienced issues such as debt, loneliness and housing problems.
- In response to an increasing number of patients with musculoskeletal problems, the practice established sports and exercise medicine appointments in-house. This offered a one stop service that provided patients with specialist care, helped increase the knowledge of clinicians and reduced the need for referrals to secondary care.
- When people with complex needs approached the practice for help, staff provided an immediate

multidisciplinary response to meet their needs. For example, when the parent of an acutely ill child from a vulnerable community outside of the local area approached the practice, a GP convened a case conference with the patient's own GP, a consultant, the community navigator and community nursing team. This resulted in the family receiving rapid specialist help.

Access to the service

Appointments were from 8.30am to 6.30pm Monday to Friday. Saturday morning appointments were available on alternate weeks and the service offered Sunday flu clinics. The practice offered commuter appointments from 7am on demand and after-school appointments from 6.30pm to 8pm two evenings per week.

In addition to pre-bookable appointments that could be booked up to one month in advance, the practice provided a daily GP-led triage service for patients who needed an urgent home visit or telephone appointment.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. To meet the increasing demands of the local population, the practice had established an online virtual surgery. This gave patients access to an online 'common illness room' that enabled them to seek advice from a GP about non-urgent conditions. The virtual surgery included information for managing long-term conditions and aimed to empower patients to take the lead on improving their health.

- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 81% and the national average of 79%.
- 63% of patients said they could get through easily to the practice by phone compared to the CCG average of 78% and the national average of 73%. Since these data were published, the practice had implemented improved access. This included additional phone lines and a structured triage system available during the practice's busiest times.

The practice had a system in place to assess:

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

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice received 13 complaints from March 2015 to November 2016.

The practice had an effective system in place for handling complaints and concerns, led by the clinical and non-clinical complaints managers.

- The practice manager and a GP partner met weekly to discuss complaints. This ensured complaints were investigated and resolved quickly. An annual complaint summary meeting involved all practice staff and ensured themes and trends were identified to help improve the service.
- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system

We looked at all complaints received in the last 12 months and found in each case the practice manager documented a review and action. This included evidence of the initial action taken in each case and what they did afterwards to improve the service. In addition, the practice conducted specific reviews when patients submitted concerns or requests.

Lessons were learnt from complaints and changes were made as a result of analysis of trends and action. For example following comments from patients, staff ensured they made outgoing calls in the afternoon and GPs used practice mobile phones to call patients. This meant phone lines to the practice were maintained for patients who wanted to make an appointment. In addition, the practice provided extra administrative support to cover staff absences to ensure referrals and documentation were completed promptly. In addition, as a result of a complaint, the practice provided detailed information on repeat

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

prescriptions and other processes to help inform patients. This included information on the referral process to secondary care, how to access results and the practice's standard for waiting times to be seen.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

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

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. Each member of the team had the opportunity to contribute to the mission statement and vision of the practice we and saw they were passionate about its success.
- The practice had a robust strategy and supporting business plan that reflected the vision and values and were regularly monitored. This included regular reviews in staff meetings and discussion with the patient participation group (PPG) about how to continually improve the service.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained by the leadership team.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Processes ensured the whole practice team were involved in learning and outcomes such as by ensuring registrars and salaried GPs attended partner meetings.

Leadership and culture

On the day of our inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. There was a track record of prioritising safe, high quality and compassionate care within a culture of 'no blame'. This meant staff were supported to learn from mistakes without fear of reprisal. All of the staff we spoke with told us the partners were approachable and always took the time to listen.

The practice had an ethos of promoting staff development and investing in training. Some staff had developed their roles and careers in the practice. For example, 70% of permanent GPs had been trained in the surgery and non-clinical staff had developed professionally into more senior roles, such as a carers' champion. It was clear from our discussions and observations that the senior team promoted staff cohesion, including through social events and away days. Clinical staff told us they had opportunities to reflect on practice as a strategy to improve and develop their work.

The leadership structure also extended into the locality through project input based on the Gosport Vanguard model to enable the practice to increase the number of same-day appointments.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were twice annually.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Outstanding ☆

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the PPG and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. The PPG proactively sought membership from a wide representation of the practice population, including in age range, gender and health status.
- The practice had gathered feedback from staff through appraisals, meetings and away days. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- A GP acted as a dedicated lead for the website, IT and access. This had resulted in improved communication access for all patients, including effective use of social media to advertise health events and other services offered by the practice.
- The PPG was a member of the CCG patient participation network. This meant the group had access to shared learning and strategy events as a way to share best practice and learn from activities elsewhere in the area. The PPG also held periodic education evenings to present the work of the network and help provide patients and their relatives with information on local services.
- The practice proactively involved patients to develop the services. For example, expert patients worked with staff to provide education and information sessions to other patients and those in the community. This included through scheduled sessions in the practice and during healthy living events. In addition, extra reception staff and phone lines had been added each morning to meet demand for appointments and the reception area had been reorganised to improve privacy and confidentiality at the counter.
- The practice produced a quarterly newsletter to keep patients up to date with opening hours, special events and programmes. The PPG used the newsletter to communicate its work and to encourage others to join it.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

The practice had been recognised nationally for its innovative work in supporting carers and in developing a community navigators programme. This led to the practice staff being awarded a Health Service Journal Value in Health Care Award in 2015. In addition, the housebound project was recognised by the Royal College of General Practitioners (RCGP) and staff were selected to present their work at the annual conference in 2016.

A GP trainee had secured funding to develop a mobile phone app that would allow GPs to more easily recognise cancer risks when patients presented with a group of symptoms.

The practice had launched a digital virtual surgery to meet the access and clinical needs of patients. This was an electronic online platform that enabled patients to access advice, care and support through one of eight virtual 'rooms' accessible through the practice website. This included GP-led reviews, medicines advice and prescriptions. There was evidence the service had an immediate positive impact on patient outcomes. For example, one patient used the service to explain a knee problem to a GP. The GP lead was able to provide a knee score assessment to the patient to complete remotely and then submit electronically. As a result the patient received a rapid, appropriate specialist referral that led to the timely diagnosis of a knee condition.

Following the establishment of a housebound patient care protocol, the practice prepared a housebound service development plan to drive ongoing review and improvement. This included plans to integrate practice registrars with the service following specialist training on

Are services well-led?

Outstanding ☆

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

the template. The development included a strategy to broaden specialist input into the service, including from two geriatricians, a frailty consultant and a frailty educator team. This would increase the scope of the service and broaden staff training.

The practice had a quality improvement and assurance plan that focused on the quality of services and addressing the health inequalities of the local population. The plan used quality improvement strategies from appropriate organisations including the RCGP and local government and voluntary groups. Staff also looked at quality improvement plans used outside of England to identify opportunities for piloting and improvement. For example, key elements of the NHS Scotland Improvement Journey had been incorporated into the plan to help staff plan and track quality on a long-term basis.