Garston Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 8

Areas for improvement 8

Detailed findings from this inspection

Our inspection team 9

Background to Garston Medical Centre 9

Why we carried out this inspection 9

How we carried out this inspection 9

Detailed findings 11

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Garston Medical Centre on 7 May 2015. Overall the practice is rated as good.

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

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

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

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

Importantly the provider should:

Summary of findings

- Ensure that all staff undertake infection control training.
- Ensure a fire drill takes place.
- Amend the locum/trainee information pack to include emergency procedures.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed with the exception of medicines and infection control where there had been some omissions, which have subsequently been addressed. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. The national data showed that patients rated the practice slightly below that of other practices in the locality, however, this did not concur with the practice patient survey which showed high level of satisfaction in line with the locality. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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

Summary of findings

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. The practice learned from complaints and shared learning with all staff.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors and midwives.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for them people and other vulnerable patients.

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

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as MIND. 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 left comment cards for patients to complete prior to our inspection. We collected comments from 34 patients and all cards reported positive comments regarding the service they received at the practice. Patients reported that they were treated with kindness and respect by GPs, nurses and reception staff.

There were comments regarding specific GPs and of the support and information patients had received when adapting to a diagnosis of long term conditions. Along with the positive comments some patients referred to difficulty getting through on the telephone to book an appointment on the same day. We spoke with five patients who also reported similar experience of the practice but spoke positively of the care received.

The national patient survey also showed that a higher number of patients experienced more difficulty getting through on the telephone that that of other practices in the area. However, the results of the survey were from the patient survey in 2014 and during our inspection, the practice demonstrated that work had taken place to address this since the survey.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all staff undertake infection control training.
- Ensure a fire drill takes place.

Amend the locum/trainee information pack to include emergency procedures.

Garston Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a specialist adviser who was a practice manager.

Background to Garston Medical Centre

Garston Medical Centre provides general medical services to patients in the Garston and surrounding areas of North Watford. The practice provides services under a general medical services (GMS) contract to a population of approximately 11,200 patients. There are two male GPs partners and three salaried female GPs, three practice nurses a health care assistant and practice manager, who are supported by reception and administrative staff. It is a teaching practice which accommodates, trains and supports Foundation Year 2 doctors and registrars who are training to be GPs. (Foundation 2 doctors are qualified doctors who are on year two of a two year training programme to develop their skills under supervision in various areas of medicine).

The practice operate from a single storey building in Garston. The practice population is made up of a higher than average number of patients between the ages of 0 and 10 years and 25 to 49 years and data indicates that the area is not one with a high level of deprivation.

When the practice is closed, an out of hours service is provided by Hertford Urgent Care.

Why we carried out this inspection

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

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 7 May 2015. During our inspection we spoke with a range of staff including GPs, the practice manager, nurses and reception and administration staff. We observed how staff assisted patients and family members when they attended the practice, looked at staff records and reviewed policies and procedures and health promotion information available at the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Discussions with the partners showed that they meet daily after morning consultations to share issues received from the post and other sources to ensure they were dealt with in a timely way. This also provided an opportunity to discuss any safety issues. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. We saw evidence of the folder where safety alerts were kept and saw that they showed the action taken when relevant. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

Discussions with all staff demonstrated the practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents which was understood and used by all staff in the practice. There were records of significant events that had occurred during the last two years and we were able to review these. An annual review of these was also provided prior to inspection which did not identify any themes. Whilst significant events were not a standing agenda item, we saw from minutes that they were discussed as and when they occurred and the practice manager collated them to discuss at a formal quarterly meeting.

There was evidence that the practice had learned from these and that the findings were shared with relevant staff. GPs as well as receptionists, administration and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used paper incident forms which were completed and sent to the practice manager. They showed us the system used to manage and monitor incidents and we tracked some incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example we noted a change in the process of dealing with information received from the hospital when a result had not been seen by the GP. We also saw how in-house training had been arranged following a medication error. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with confirmed the process and that they received and actioned them when necessary.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. They had identified a lead GP for safeguarding vulnerable adults and children who had received the appropriate training to carry out this role. They had provided an in-house training session to all staff regarding safeguarding and staff we spoke with confirmed this had taken place. Staff were all aware of who the lead GP was in the practice. They were able to describe the actions they would take and had access to laminated posters in all areas which provided them with a quick reference of who to contact and action to take if they had safeguarding concerns. They were also able to describe the signs of abuse they would look for in children and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. They were aware of their responsibilities and knew how to share information and properly record safeguarding concerns.

Staff showed us there was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example, for children subject to a child protection plan a pop up alert would appear.

There was a chaperone policy and signs to notify patients that a chaperone was available were visible in all areas of the practice. The practice manager told us that only nurses carried out chaperone duties. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or

procedure). Staff we spoke with confirmed this. All nursing staff had been trained to be a chaperone and had a criminal records check through the disclosure and barring service (DBS).

Staff told us that they had good communication links with the health visitor and would liaise with them if there were concerns with any children or if they frequently did not attend for immunisation. The practice nurse told us the procedure for following up children who had not attended after three reminders for immunisations, whereby a letter was sent followed by a call from either the practice nurse or the GP lead. The health visitor also had a regular allocated time on the multi-disciplinary meeting to allow review of vulnerable families and discuss any ongoing concerns regarding safeguarding.

Medicines management

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

Processes were in place to check vaccines were within their expiry date and suitable for use. All the vaccines we checked were within their expiry dates and the system for checking the temperature showed that these had been maintained within the appropriate limits.

The practice had a small store of medicines in a lockable case, which were kept in an isolated area at the back of reception and whilst not accessible to the public they were not stored in a locked cupboard. Also we found that one of the GPs had stored their bag in this area and contained medicines which were out of date. The GP told us they had brought these in for disposal. The practice immediately removed these and disposed of them. Following our inspection the practice manager told us they had removed the bags and medicines box and these were now stored in a secure area in a locked cupboard. They also told us they had implemented an inventory and system for checking these to ensure there is no recurrence of this and that out of date medicines were disposed of immediately. Documentary evidence was submitted to confirm this and we will check this when we next inspect the practice.

We saw minutes of practice meeting that noted the actions taken in response to a review of prescribing data. For example, they had carried out a review of specific high cost medicines following advice from the prescribing advisors to ensure effective use of resources.

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

The practice had a system in place to ensure safe monitoring of patients taking high risk medicines and used alerts on the clinical system to identify such patients. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. This was also noted on comments cards left by patients. We saw there were cleaning schedules in place and cleaning records were kept.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy. However, not all staff had received training in infection control during their induction to the practice or any ongoing training. There had also been no recent infection control audit carried out. However, the nurse told us they monitored general infection control standards as routine on a daily basis but did not complete a room by room practice audit tool to document it. We did note that the cleaning schedules had been audited. Following our inspection the practice manager contacted us to confirm that they had carried out an infection control audit, which had highlighted the need for training. They informed us that they had arranged in house training to take place in October 2015 in response to this. One of the nursing staff had also completing their training online. The practice manager provided documentary evidence to confirm this.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan

and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw that there were elbow taps and appropriate flooring in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).The practice manager had undertaken Legionella training and had commissioned a survey from external contractors. We saw the practice had acted on the survey report and carried out the appropriate checks in line with the recommendations.

Equipment

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

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Whilst the practice did keep photographic identify of their staff, we noted this was not included in the recruitment policy. Following our inspection the practice manager amended their recruitment policy to reflect their practise and sent a copy of this to us.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and divide tasks when there was a need. They also had a buddy system in place to cover when GPs were away and there was a specific member of staff responsible for organising this.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice identified risks and assessed and rated them and recorded mitigating actions to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

We saw from meeting minutes that the practice had allocated a specific line for emergency care and consultants to meet the requirements of the Risk Profiling Enhanced Service to allow outside clinicians easy access to the practice. The Risk Profiling Enhanced Service rewards practice for identifying patients who are seriously ill or at high risk of emergency hospital admission.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health

and well-being or medical emergencies. We noted during our inspection that a member of staff spent time with a patient in reception who had a sick child whilst waiting to see the doctor.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen. When we asked members of staff, they all knew the location of the equipment and records confirmed that it was checked regularly. We noted the practice did not have an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency).The GPs had discussed the need for one in the practice in the past and assessed the risk and concluded they did not require one. However, following our inspection the GPs had engaged in further discussion and informed us that an AED had been ordered for the practice in line with best practice. They also confirmed they would be including training on its use during their resuscitation training update in September 2015. Documentary evidence was received to confirm this.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. The GPs, the practice manager and the reception team leader kept copies at home and copies were also kept in the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, details of a heating company to contact if the heating system failed. During our inspection we noted an incident occurred in the patients toilets causing a flood in the waiting area and we saw that appropriate action was taken and dealt with promptly and successfully.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and we noted that a fire drill was due to be undertaken but had not been scheduled. Since our inspection the practice manager notified us that further update fire training had been arranged for November 2015 and they intended to carry out a fire drill following this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff and trainees we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The lead GPs kept up to date with any changes to NICE and cascaded to other members of the practice. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes and mental health. The practice nurses supported the work in addressing long term conditions, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Minutes of clinical meeting demonstrated that the GPs were committed to reviewing practise and exploring new ideas and input from external agencies, for example the Living Well service for patients over the age of 65.

The practice was actively involved with the local CCG prescribing advisers and a recent audit had been carried out of antibacterial medicines and a review of referrals to secondary care. We noted that they had discussed actions required to improve. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. They had good links with the district nurses and heart failure nurse and used the rapid response team for patients who needed extra care. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed regarding their medication and whether a follow up was required.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national and local guidance approved by the CCG for referral to secondary care. The practice told us that they discussed referrals at the midday meetings.

Discussions with the GPs demonstrated they were aware of the population demographics and discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The GPs had undertaken equity and diversity training on line.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us three clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of anti-depressant medicines and how actions had been recommended and shared with the partners to agree adoption of the changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, for patients with diabetes, chronic obstructive pulmonary disease and heart failure, the practice had met all the minimum standards for QOF and practice was not an outlier for any QOF or any other clinical targets.

Staff spoke positively about the culture in the practice around audit and quality improvement and shared learning. There was an expectation that GPs would carry out regular clinical audit and one of the trainees we spoke with told us about an audit they were currently undertaking which they planned to re-audit after the first cycle was complete.

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines and the GPs logged the reason for prescribing if necessary. The practice had a dedicated prescription clerk who worked with clear guidance and a written protocol. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and the GP partners had a daily meeting where they could discuss any issues or concerns as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. We saw that the practice had carried out an audit of antibiotic prescribing as one of the doctors was an outlier. This showed the change planned as a result of the audit. We also saw the audit and the minutes of a prescribing visit from the CCG.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example they had employed a new practice nurse who was undertaking new procedures and had arranged training to ensure they were competent to carry out the tasks, such as ear syringing. The practice was a training practice and doctors who were training to be GPs were offered extended appointments of 30 minutes and had access to a senior GP throughout the day for support and had an opportunity to debrief after clinical sessions. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and family planning. Those with extended roles who managed patients with long term conditions such as diabetes, chronic obstructive pulmonary disease and asthma had received additional training to enable them to carry out these roles effectively.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GPs were responsible for amending the records and ensuring actions took place as a result of communication from other agencies. The practice had a rota system in operation which showed who would be responsible if a GP was absent which was kept on the notice board to inform all staff. We noted that communication was good within the practice and with outside agencies, such as palliative care nurses, district nurses and other practices in the locality. All staff we spoke with understood their roles and felt the system in place worked well.

The practice worked closely with the CCG locality and had committed to use the paediatric urgent care pathways that had been developed. These provided an agreed approach to care between primary and secondary care providers.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice told us they worked with the rapid response team to help reduce hospital admissions for those patients who were at high risk and had care plans.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example

Good

Are services effective?

(for example, treatment is effective)

those with end of life care needs or children on the at risk register. These meetings were attended by palliative care nurses, district nurses and the health visitor and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice had a system to communicate with other providers. For example, as neither the out of hours provider or the A&E department could access patient records the practice sent an electronic update to the out of hours clinician for recording in the notes. Electronic systems were also in place for making referrals, and the practice made referrals using the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use. Any paper communication was read and scanned into the patient's records.

For emergency patients, there was a policy whereby they verbally discussed with the on call hospital doctor and provided a letter for the patient to take with them. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. The GPs had received training in the MCA and other staff confirmed that training in MCA was scheduled to take place the following week. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it. The practice nurse we spoke with gave examples of how they showed equipment to patients to help them gain a better understanding of procedures prior to agreement to treatment. They were also able to demonstrated ways of assessing capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures we saw a written consent form was in use. For families with young children the practice utilised the child health record for immunisation consent.

Health promotion and prevention

The practice met regularly with the CCG to discuss the implications and share information about the needs of the local population which they collated from a variety of sources. This information was used to help focus on specific health promotion activity.

New patients who registered with the practice would be invited for a health review if they had any long term condition which was due for review, otherwise new patients were able to attend when they needed to. The GP was informed of all health concerns detected at review and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, patients with hypertension who opted to purchase their own blood pressure monitoring machine were given record sheets by the GP to allow them to submit to the practice for review at any time in addition to their regular review.

Older people all had a named GP and all of those at high risk of admission to hospital had care plans with regular reviews. The practice also carried out dementia screening with the lead GP as part of this review. Any vulnerable patients who were identified with mental health problems were referred to the mental health lead GP to discuss with the patient the best options for support and on-going care,

Good

Are services effective?

(for example, treatment is effective)

treatment and monitoring. All vulnerable patients and those with safeguarding issues were discussed at the multidisciplinary meeting held monthly and changes made in care as appropriate.

The practice provide smoking cessation clinics which were led by the practice nurse who had been specially trained in this area. They also offered NHS Health Checks to patients aged 40 to 75 years and we noted they had completed over 500 in the last year. Patients with any anomalies noted as a result were followed up within an appropriate timescale.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. We saw that 16 out of 28 patients on the register had attended for this check in the last 12 months. Vulnerable patients with care plans were reviewed quarterly and the computer system was used to set up alerts to ensure this happened.

The practice's performance for cervical screening was 82.6%, which was in line with others in the CCG area and the practice followed the recommended guidance on following up non-attenders. The practice offered chlamydia screening packs to patients under the age of 25 and told us they would treat if necessary.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was 96% which was in line with the CCG average, and again there was a clear policy for following up non-attenders by the lead GP or nurse. The midwife from the local health trust attended the practice to provide care and advice and to women and families during pregnancy. Well man clinics were also available to promote male health.

The practice had access a wide variety of services to refer patients to in order to promote improved health outcomes and self-care. For example, the Improving Access to Psychological Therapies (IAPT) service and the mental health team as well as signposting patients to support agencies such as MIND.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey which was published in January 2015. We saw that 111 patients had submitted their views in the national survey. The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. However, whilst the results showed that 76% of patients said that the GPs were good at giving enough time, this was below the clinical commissioning group (CCG) average of 87%. However, the practice had also conducted its own survey for which had received 140 responses with 86% of patients stating they thought the practice was good or excellent. The practice satisfaction scores on consultations with doctors and nurses were good with 82% of practice respondents saying the GP was good at listening to them and 71% saying the GP treated them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Although all of the comments were positive, some also commented on experiencing difficulty in getting an appointment on the same day. We also spoke with five patients on the day of our inspection who all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw a sign requesting patients to stand back from the reception desk to maintain confidentiality whilst other patients were being checked in. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of minutes from a practice meeting which showed appropriate actions had been taken in response to abuse from patients.

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

Care planning and involvement in decisions about care and treatment

We spoke to five patients during our inspection gave positive comments regarding their involvement in their care and treatment. They told us the GPs explained their condition and the action of any prescribed medicines. One patient told us that they felt their long term condition was managed well and they were given details and information about how they could manage it themselves. They said they were sent for in a timely manner and felt well looked after. However, the national patient survey showed a less positive response to questions of involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 65% of practice respondents said the GP involved them in care decisions and 77% felt the GP was good at explaining treatment and results compared with the CCG average of 81% and 87% respectively.

Patients we spoke with on the day of our inspection also told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received confirmed that patients were supported during periods of ill health, particularly when they were coming to terms with a long term condition. Patients told us that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, the GPs would send a hand written condolence letter if appropriate. They also had a system where they would print off the last communication with the patient and take to the end of life care meeting to identify if anything could have been done differently.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice confirmed this and told us they were actively engaged with the CCG. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. We saw that the practice had implemented coding of obese children and subsequent referral to support groups to those families to help manage obesity. They had also introduced a new care pathway regarding urine infections to prevent patients in care homes being admitted to hospital.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, availability of online appointment booking.

The practice offered double appointments for patients who needed them and nurses appointments were at mixed times to allow varied access to suit all patients' needs. The GPs visited two care homes in the practice catchment area when required and reviewed care plans whenever necessary. We saw that the practice had monitored telephone appointments over a two week period to assess patients' demands.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Homeless patients were directed to a centre who dealt specifically with the homeless and those with drug and alcohol problems and could offer more specialist services.

The practice had access to translation services which were booked in advance by reception staff. We saw there was a sign advertising that translation service was available and that the use of the translation service had been discussed in a practice meeting.

We noted that three staff were booked on external equality and diversity training later this year. Staff we spoke with confirmed this.

The premises was suitable for patients with mobility difficulties and who used mobility aids. It was a single storey ground level building which had a ramp leading to the entrance. The reception area was open and large enough to accommodate wheelchairs and prams and allowed easy access to the treatment and consulting rooms. We noted that there was a hearing loop in the reception area for those patients with hearing difficulties.

Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8:30 am to 5.50 pm Monday to Friday with extended appointment times available from 7am until 8am on Wednesday and 6.30pm until 9pm on Tuesday. A walk in surgery was held daily from 8.30am to 11am by one GP for patients who needed an appointment that day and all GPs were available to take calls for an hour each day. During the winter months the practice held Saturday and Sunday appointments to cope with winter pressures, which also allowed more opportunity for patients to attend for reviews such as those with a learning disability and diabetes.

Information was available to patients on the practice website about the surgery opening hours and included information regarding urgent appointments on the day and out of hours provision when the practice was closed. Appointment times were also advertised outside the front door of the surgery.

If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring for the out of hours provider from Hertfordshire Urgent Care. The practice leaflet also contained comprehensive details of service provision.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes whenever requested.

Patients were generally satisfied with the appointments system although had expressed concerns regarding availability of appointments in the past, which the practice had addressed and introduced measures to improve this. The introduction of the daily walk in session and electronic prescribing had removed the pressure from the telephone system and enabled easier access. Patients confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to access this.

The practice's extended opening hours was particularly useful to patients with work commitments. This was confirmed by patients we spoke with and from comment cards.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. 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 which was displayed on the notice board in the surgery as well as in the practice leaflet and the website. There were also leaflets available for patients to take away. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the folder that contained the complaints received in the last 12 months and found they had been recorded and acted on appropriately.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and saw that lessons learned from individual complaints had been acted on. We noted the practice had identified that the main theme for complaints was the telephone system and lack of appointments, which they had addressed and monitoring was ongoing. We noted that this was also an action resulting from the patient participation group concerns. We saw evidence of commitment to continued monitoring to determine if further telephone lines were required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff we spoke with told us they felt clear about what the practice vision was and that the GPs and all the practice were committed to achieving this. They told us the practice was open and honest and committed to always achieving the best for patients.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff told us they felt involved in the practice that their views and opinions were valued.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a policy file which all staff had access to. We looked at a number of these policies and procedures and saw they were appropriate, but there were some where the author/ owner was not always clear or who the person responsible was. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. There were also leading GPs for clinical areas, such as diabetes and asthma and other areas of the QOF. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it had almost maximum achievement, which was above the national and CCG average in all areas with the exception of learning disabilities. However, the practice told us they had a high DNA rate and had offered weekend appointments to help improve attendance. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice told us about a local peer review system they took part in with neighbouring GP practices which the GP and practice manager attended and would feed back to the practice.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw audits that had been carried out for antibiotic prescribing and changes made as a result.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us individual risks that had been identified and addressed such as fire assessment and legionella. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented in all areas except infection control where documented audit had not been completed and fire drill which was due. However, following our inspection we received evidence to demonstrate that this has now been addressed.

The practice held monthly meetings which included discussion regarding any areas of risk. The practice partners also met daily and discussed any issues or areas of concern that had been raised. We looked at minutes from meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We noted from minutes of meetings that staff had raised concerns and actions had been agreed to address them. They told us that the GPs and practice manager were supportive and made them feel involved and an important part in the practice. We saw that the lead GP had organised an urgent meeting to address concerns from staff regarding verbal abuse from external sources. Staff had been supported through this and appropriate action taken.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We were shown the

Are services well-led?

Good

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

practice staff and policies folder that was available to all staff, which included sections on equality, harassment and bullying at work and whistleblowing. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient questionnaires, online patient feedback and complaints. The feedback and complaints from patients informed the practice that telephone access and getting an appointment was their main concern. We saw that in response to this the practice had introduced telephone consultation appointments, a daily morning walk in surgery and electronic repeat prescribing.

The practice patient participation group (PPG) was a virtual one which they communicated with online. We saw that the practice had been trying to increase the membership. They had posters and forms available at reception and they told us the reception staff were trained to encourage patients to join. They had also tried to encourage young male patients via opportunistic meetings at the well man clinics and older patients were encouraged during consultations. The PPG included representatives from various ethnic groups such as Indian and Chinese, but were predominantly white British. The PPG members were encouraged to provide feedback throughout the year and a review of comments was produced annually which the practice provided for us.

The practice had gathered feedback from staff through appraisal and regular meeting, but staff told us the ethos of the practice was one of openness and honesty. They reported 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 in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place that included a personal development plan. However, we noted that the practice manager had not had an appraisal for two years. Following our inspection, the practice manager informed us that their appraisal had now been arranged to take place in July 2015. Staff told us that the practice was supportive of training and that they attended the sessions arranged by the CCG where guest speakers and trainers attended.

The practice was a GP training practice and trained registrars who were qualified doctors who wanted to become GPs. The trainees and locum GPs had access to a pack with comprehensive information regarding the practice. However, we noted that the pack did not contain information regarding emergency procedures. The trainee we spoke with told us they were very well supported and had access to the GPs to discuss any issues regarding their experiences. We saw that appraisals took place for trainees and for salaried doctors.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.