Lodge Surgery

Quality Report

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Date of inspection visit: 05/03/2015
Date of publication: 20/08/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lodge Surgery on 5 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led 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 report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice 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.
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

However, there were also areas of practice where the provider needs to make improvements. The provider should:

- Ensure a record of the risk assessment is kept on file for those staff that are assessed as not needing a Disclosure and Barring Service (DBS) check

Summary of findings

- Keep a record of any health and safety risk assessments related to the buildings and the environment

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

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

Summary of findings

responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was a virtual patient participation group (PPG). 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. The practice offered proactive care to meet the needs of the older people in its population for example, in dementia and end of life care. There was a named GP for patients over 75 years of age. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice participated in a care home initiative and had a designated clinician to look after the needs of patients that lived in care homes.

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. 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. The practice offered longer consultation time with a GP for those patients that needed it.

Families, children and young people

Good

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example it offered appointments in the evenings and

Summary of findings

Saturday mornings to facilitate working age people. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. It offered NHS health checks and cervical screening.

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 with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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).There was a GP lead for mental health who 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.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection. They told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

We reviewed 18 CQC comment cards which had been completed by patients prior to our inspection.

All were complimentary about the practice, staff who worked there and the quality of service and care provided. Patients commented that the staff were very caring and helpful. They had been treated with respect and dignity at all times and they found the premises to be clean and tidy.

In the national patient survey 2015, patients had responded favourably to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the survey showed 83% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. Both these results were comparable to the local CCG and national average.

Areas for improvement

Action the service SHOULD take to improve

- Ensure a record of risk assessment is kept on file for those staff that are assessed as not needing a Disclosure and Barring Service (DBS) check
- Keep a record of any health and safety risk assessments related to the buildings and the environment

Lodge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor.

Background to Lodge Surgery

Lodge Surgery provides a range of primary medical services to the residents of St Albans including London Colney and Sandridge in Hertfordshire. Established in 1906 the Lodge Surgery has a long local tradition of providing family medicine and a teaching environment for doctors and nurses. The practice ethos is to 'provide the best possible standard of medical care and to reach these standards with honesty and integrity'.

The practice population is predominantly white British but also serves patients from the ethnic minority groups. National data indicates that the area served is one with a low level of deprivation. The practice has approximately 12300 patients and provides services under a general medical services contract (GMS). The GMS contract is one between general practices and NHS England for delivering primary care services to local communities. There is a branch surgery, the Highfield Surgery situated at 1 Jacob Court, 61 Russet Drive, St Albans. Patients can access either surgery and staff work across the two sites. We did not inspect Highfield surgery at this time.

Lodge surgery is a teaching practice which trains and supports medical students and qualified doctors who are training to be GPs.

Clinical staff at this practice include three GP partners, seven other GPs, a nurse practitioner and three practice nurses. Management, administration and reception staff support the practice. Community nurses and other healthcare professionals such as a community matron, a Macmillan nurse, a midwife, a dietician, counsellors and health visitors from the local NHS trust also provide a service at this practice. A mix of male and female clinical staff is available.

Lodge surgery is open between 8am and 6.30pm Monday to Friday and offers Saturday opening from 8.15am till 12.30pm except on Saturdays that are bank holidays when there is no service.

Highfield Surgery is open between 8am and 6.00pm Monday to Friday and is open on the first Saturday of each month from 8.15am till 12.30pm.

The Lodge surgery and its branch surgery were last inspected in January 2014. At that time inspectors found both the Lodge and its branch surgery was not meeting regulation 12, HSCA 2008 (Regulated Activities) regulations 2010 related to cleanliness and infection control, and regulation 13, HSCA 2008 (Regulated Activities) regulations 2010 related to management of medicines. Checking compliance with the above previous breaches was a consideration in planning this inspection.

When the practice is closed out-of- hours services are provided by Herts Urgent Care and can be accessed via NHS 111.

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

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 March 2015. During our visit we spoke with a range of staff including GPs, practice manager, business manager, nurses, reception and administration staff. We spoke with patients who used the service and we observed how people were dealt with by staff during their visit to the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff had reported an incident related to hazardous waste disposal. We saw that the practice had reviewed its waste management arrangements and had trained staff in the correct waste disposal procedure.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred during 2013 and saw this system was followed appropriately. Significant events where appropriate were discussed during the monthly practice clinical meeting. Information relevant to non clinical staff was discussed during the support staff meeting. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff reported incidents to the practice manager who showed us the system used to manage and monitor incidents. There was an incident book where all reported incidents were logged. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example the practice had taken action to review all patients who had a diabetic passport (this documents the patient's current insulin products and enables a safety check for prescribing, dispensing and administration) following a safety incident and had trained staff on the appropriate issue of these passports.

National patient safety alerts were disseminated to practice staff through discussion at monthly practice clinical meeting.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had a GP lead in safeguarding vulnerable adults and another GP lead in safeguarding children. Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues for example the management of 'looked after children' who are children that need specific protection in the community. There was a system to review vulnerable patients who had not attended scheduled appointments to see a clinician.

We saw that the practice team had regular contacts with the health visitor, and other clinical and relevant staff to discuss ongoing safeguarding issues and agree plans for keeping patients safe. The safeguarding lead or a nominated representative attended child protection case conferences and reviews where appropriate.

We spoke with the community matron, the midwife and the health visitor from the local NHS trust. They told us that they worked well with the GPs and practice staff in safeguarding vulnerable adults and children and usually attended monthly multidisciplinary team (MDT) meetings. The health visitor and the community matron gave us a recent example of joint working where the MDT had worked with other agencies to safeguard a baby.

A chaperone was available if required. 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 that chaperoning was carried out by clinical staff only and they clearly explained to us what their responsibilities were to keep patients safe from the risk of abuse, including where to stand to be able to observe the examination.

The practice had a designated GP who provided care to people that lived in care homes in St Albans. This included identifying the needs of the vulnerable adults that were resident within these homes. The GP told us that where necessary they provided double appointments so patients could be given more time to discuss their care needs. Home visits were provided for those that needed one.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a process for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

When we inspected in January 2014 we found that the practice had not made appropriate arrangements for the obtaining, recording, storage and administration of prescription-only medicines kept on the premises. During this inspection we found that the practice had made appropriate arrangements. The practice manager confirmed that prescription-only medicines were now stored in a locked cupboard at the Lodge surgery and the branch surgery. We checked and found this to be the case at Lodge surgery. We did not inspect the branch surgery at this time but the practice manager confirmed in writing that a similar arrangement was in place at the branch surgery. There was also a log that recorded when stocks were acquired and administered.

Previously when we inspected in January 2014 we found that emergency medicines were not easily accessible to staff. During this inspection we found that the practice had acted to make emergency medicines easily accessible to staff. We saw that these were held in a trolley that was available in the treatment room at Lodge surgery. The practice manager confirmed in writing that a similar arrangement was in place at the branch surgery. Staff we spoke with knew its location.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that the nurses had received appropriate training to administer the medicines referred to under a PGD. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a lead GP responsible for medicine management. They met regularly with the local clinical commissioning group and reviewed prescribing data.

We saw a positive culture in the practice for reporting and learning from medicines related incidents. For example the practice had reported and investigated an incident initially attributed to the administration of a vaccine which on investigation was found to be unrelated. Nevertheless following this incident the practice had reinforced emergency procedures staff should take in similar situations.

A review of prescribing data, for example, patterns of antibiotic and hypnotics prescribing within the practice showed that the practice performance was in line with national trends.

Cleanliness and infection control

When we inspected in January 2014 we found that the practice had not operated effective systems to assess the risk of and to prevent the spread of a healthcare associated infection. During this inspection we found that the practice had made appropriate arrangements.

We observed all areas of the practice to be clean, tidy and well maintained. We saw there were cleaning schedules in

Good

Are services safe?

place and these were regularly checked by the practice manager. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had an infection control policy and there was a responsible GP lead assisted by the practice manager and a practice nurse who took responsibility for practical implementation of non clinical and clinical issues respectively. We saw that all staff had received recent infection control training. In addition the practice manager after our inspection wrote to us and confirmed that the GP lead, the practice manager and the designated practice nurse had undergone specific infection control training in March 2015.

We saw evidence of a recent infection audit for Lodge surgery as well as the branch surgery. There was an action plan developed and the practice manager told us that this had been ratified during a partner's meeting and action was on going. We saw evidence that infection control issues were reviewed during clinical team meetings as appropriate.

Aprons, gloves and other protective equipment were available in all treatment areas as was hand sanitizer and safe hand washing guidance.

The practice had a process to accept specimens such as urine samples brought in by patients for onward transmission to the hospital laboratory. There was a specimen refrigerator and staff had been trained in the safe acceptance and storage of specimens.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. All waste bins were visibly clean and in good working order.

A legionella risk assessment had been carried out. Legionella is a germ found in the environment which can contaminate water systems in buildings.

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. We saw records that demonstrated all medical devices had been calibrated and that all portable electrical equipment had been tested in October 2014 to ensure they were safe to use. The calibrated equipment included weighing scales and spirometer, a device used to measure the movement of air into and out of the lungs.

Staffing and recruitment

The three staff 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). Not all non clinical staff had received DBS checks. The practice manage told us that they risk assessed the need for such checks. Non clinical staff who did not have direct contact with patients were not DBS checked. We however did not see a record of the written risk assessment on file for such employees.

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. Staffing was usually reviewed during partners meetings where actual staffing levels and skill mix were reviewed in line with planned staffing requirements. GPs and nurses operated a buddy system and planned their annual leave in conjunction with each other to ensure sufficient clinical cover at all times. There was also an arrangement in place for administrative staff, to cover each other's annual leave.

Monitoring safety and responding to risk

We saw policies in place to support health and safety. We saw evidence of a recent fire risk assessment that ensured staff and patients were not at risk. The last fire drill had taken place in 2013 and the practice manager told us that a refresher drill was planned to happen in 2015.

The practice manager told us that they undertook regular health and safety checks of the building but we did not see any documented evidence to this effect.

The practice had arrangements for identifying those patients who may be at risk. There were practice registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The clinical support and needs of such patients were discussed during clinical meetings. The practice computer system was used to inform staff of individual patients who might be particularly vulnerable.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

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

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 this equipment and records confirmed that it was checked regularly. However we did not see a warning sign on the door of the room where the oxygen was to alert the fire service of the presence of oxygen if a fire were to occur at the practice. Following our inspection the practice manager confirmed in writing that a notice was now in place to alert the presence of oxygen.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Practice staff accessed these through a computerised system which was readily available in all the clinical and consulting rooms.

The implications of guidelines for patients and the practice's performance were discussed during clinical meetings and we saw records of this. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with current best practice guidance, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart and lung disease and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We reviewed the data of the practice's performance for antibiotic prescribing, which was comparable to similar practices nationally.

Patients with long term conditions were managed in a variety of ways. For example the practice register of people with learning disabilities that needed support and who were offered annual reviews. Similarly it maintained a register of patients with palliative care needs and worked with other professionals in the community to meet their needs. The practice had identified their patients most at risk of an unplanned hospital admission and taken steps to ensure that these patients were fully involved with their GP in developing a fully comprehensive personal care plan.

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.

Management, monitoring and improving outcomes for people

The GP partners monitored how well the practice performed against key clinical performance indicators such as those contained within the QOF (QOF is a voluntary incentive scheme for GP practices in the UK which financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). Staff across the practice had key roles in monitoring and improving outcomes for patients and there were designated leads for safeguarding, palliative care, medicines management and referrals as well as for other long term conditions.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice had a high QOF achievement. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar or better to the national average for some indicators.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related indicators was similar to the national average.
- The dementia diagnosis rate was comparable to the national average.

The practice had a system in place for completing clinical audit cycles. We reviewed seven clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care had been made where needed and the audit repeated (or had a plan for a repeat audit) to ensure outcomes for patients had improved. For example, an audit of two types of medicines prescribed to patients to prevent a blood clot had resulted in a change to a more appropriate medicine.

The practice followed the prescribing guidelines developed by the local clinical commissioning group (CCG). A recent CCG audit has shown that the practice was one of the best performing practices in the local area. The lead GP responsible for medicine management attended a prescribing meeting hosted by the local CCG every six to eight weeks. This was a forum to discuss prescribing issues collectively and to learn from each other. There was a

Good

Are services effective?

(for example, treatment is effective)

protocol for repeat prescribing which followed national guidance. Staff were aware of the action to take when a patient had reached the authorised number of repeat prescriptions.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There were registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The clinical support and needs of such patients were discussed during clinical meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending essential 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).

Staff undertook annual appraisals. These were usually carried out by their sector lead, for example the practice manager by two GP partners, the nurses by the lead nurse and administration staff by the practice manager.

The practice was a training practice for qualified doctors who were training to be GPs. Trainee GPs had access to a senior GP throughout the day for support and had an opportunity to discuss their training experience after clinical sessions. The trainee we spoke with was very positive about the opportunities provided by the practice.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, one nurse told us that they had completed a diploma course in the management of patients with asthma, while another nurse told us that they had undertaken training in leg ulcer management. Nurses were also trained on administration of vaccines, cervical cytology and had received appropriate training to fulfil their roles in the management of patients with long term conditions.

The practice had a process to identify and manage poor performance.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communication from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and acting on any issues from communications with other care providers. They understood their roles and how the practice's systems worked.

There was a system to review results such as those from blood tests, x-rays, scans and other communications. The GPs operated a buddy system so there was always a GP available to review the results and communications, even when the responsible GP was on holiday. There was an on call GP who reviewed any urgent test results and communications received.

The practice demonstrated they worked with other services to deliver effective care and treatment across the different patient population groups. The practice held regular multidisciplinary team meetings to discuss palliative care patients, vulnerable children and patients discharged form hospitals with complex needs. These meetings were usually attended by the health visitor, the community matron, the community midwife, community nurse, and the palliative care team.

We found appropriate end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider and the ambulance services.

Information sharing

The practice used electronic and paper systems to communicate with other providers. There was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency. The practice had also signed up to the electronic Summary Care Record and planned to

Good

Are services effective?

(for example, treatment is effective)

have this fully operational by April 2015. (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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

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

Staff were also aware of the Gillick competency test (a process to assess whether children under 16 years old are able to consent to their medical treatment, without the need for parental permission or knowledge) and had received training from Medical Protection Society.

Consent for minor surgical procedures were obtained from patients and these were scanned into individual patient records. We saw the results of a recent audit which showed that clinicians had explained to the patients the clinical indications and possible complications of the proposed procedure before consent was obtained.

Health promotion and prevention

The practice held a number of clinics which could be accessed by appointment and also offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations in the 12 month age group was in line with the national average. There was a policy for following up non-attenders by the practice nurse.

It was practice policy to offer a health check to all new patients registering with the practice. The GPs were informed of all health concerns detected and these were followed up in a timely way.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of patients with physical and/or mental health conditions and offered nurse-led smoking cessation clinics. The practice also offered chlamydia screening opportunistically for its younger patients.

The practice's performance for the cervical screening programme was 83% which was in line with the national average. The practice nurses had responsibility for following up patients who did not attend.

The nurse told us that they held flu clinics and actively targeted their patients who were over 65, patients with a long term health condition, carers and patients in other defined clinical risk groups. The practice flu vaccination uptake was in line with the national average.

The practice had numerous ways of identifying patients who needed additional support, for example the practice had identified patients experiencing poor mental health and offered them an annual health check as well as longer consultation times.

The practices web site offered its patients a number of health promotion and prevention services, for example on contraception and family planning, sexual health, and counselling and mental health.

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 2015, a review of the comment cards patients completed for us and what the patients told us on the day of the inspection.

The evidence from comment cards and what patients told us on the day showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. However satisfaction levels were slightly below CCG and national expectations.

For example:

- 84% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 83% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 90% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%

We received 18 completed cards and all were positive about the service experienced. Patients commented that the GPs nurses and practice staff were facilitative caring and listened to them. Staff had treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us that the GPs and staff were courteous, helpful and caring and that they were satisfied with the care provided by the practice.

Consultations took place in private where the doors to the treatment rooms were closed during such consultations. Privacy curtains were also available in all the consultation rooms.

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. 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.

Care planning and involvement in decisions about care and treatment

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%.

We reviewed the results of a practice initiated satisfaction survey of patient with long term conditions completed in 2014. This indicated that patients were generally satisfied and felt that they were involved in decisions about their care and treatment.

Staff told us that translation services were available for patients who did not have English as a first language which was provided by the Clinical Commissioning Group (CCG).

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice.

For example:

- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 89% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent

Good

Are services caring?

with the above survey information. For example, patients we spoke with highlighted that staff responded compassionately when they needed help and provided support when required.

The practice website gave information on how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was information available on the practice website for carers to ensure they understood the various avenues of support available to them. This included signposting to Carers in Hertfordshire, a countywide service which offered support to carers and young carers.

We saw that a process was in place at the practice for recently bereaved patients to be highlighted on the electronic patient records system. The practice manager and the nurses told us that patients who were recently bereaved were contacted by the GP or a practice nurse to ascertain what support they required. Their care and support needs were further discussed during clinical meetings if required.

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 patients' 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. For example the practice had liaised with the St Albans GP forum and introduced a number of initiatives to care for patients in care homes. This included the availability of dedicated clinicians to plan and deliver their care. Each patient that lived in a care home and registered with the practice had an agreed care plan.

There was a named lead GP to look after the care needs of patients with mental health and related illness such as depression and dementia. The practice provided a counselling service and worked with the local mental health trust in providing appropriate care and support.

There was a named GP to look after the care needs of patients over 75 years old. The GP or a designated nurse made home visits for those patients, included provision of the flu immunisation when required.

The practice kept a register of patients with learning disabilities that needed support which ensured appropriate care was offered for these patients. There were currently 58 patients on this register who were all offered annual health checks.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

For children and young people the practice offered appointments outside of school hours Monday to Friday till 6.30pm and on Saturday mornings at the Lodge Surgery.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff were aware of patients for whom English was not their first language. They said they could access a translation service if required which was provided by the local council.

The practice had not arranged specific equality and diversity training. However the staff we spoke with had a good understanding of equality and diversity. Any specific issues were discussed during practice meetings and staff were actively asked for their opinions and views.

There were male and female GPs in the practice; therefore patients could choose to see a male or female GP.

The practice provided for the needs of patient with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice with ease. Accessible toilet facilities were available for all patients which included baby changing facilities. There were accessible parking spaces, step free access to the electronic front door of the practice.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and other clinical staff 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.

Practice staff told us they knew the patient list well and flexible appointments in terms of time and length of appointment times could be accommodated based on their specific needs.

The practice operated a policy to care for patients without stigma or prejudice. Homeless patients for example were able to register the same way as other eligible patients and the practice a flexible approach when providing to the needs of the individual.

Access to the service

Lodge surgery was open between 8am and 6.30pm Monday to Friday and offered Saturday opening from 8.15am till 12.30pm except on Saturdays that are bank holidays when there was no service.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

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. Home visits were routinely made to several local care homes.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas.

For example:

- 71% were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 72% described their experience of making an appointment as good compared to the CCG average of 77% and national average of 73%.
- 71% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns which was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

Information on how to make a complaint was available in the practice on a poster, leaflet and on the website. 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.

A complaints log was kept and we reviewed the 12 complaints received in the past year and found that these had been investigated and responded to in a timely manner. The practice manager told us that complaints received were discussed during practice meetings so they were able to learn and contribute to determining any improvements that may be required. Staff we spoke with were aware of the system in place to deal with complaints.

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 the highest quality patient care by providing 'safe healthcare from conception to death based on recognised evidence based medicine'. Staff we spoke with all knew and understood the vision and values and knew what their responsibilities were in relation to these.

All staff spoke positively about the leadership and told us they felt valued as employees. They told us central to the practice values were the needs of patients and this was taken into account in their decision making, planning and development.

Governance arrangements

The practice had a range of policies and procedures and these were all available on the practice computer system where members of the team could access them. All staff we spoke with knew how to access these and were able to direct us to a number of electronic policies and procedures. The practice had a whistleblowing policy which was also available to all staff.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for infection control, lead GP each for safeguarding adults and children and a lead GP for medicine management. The practice had a clinical governance meeting once a month. Major clinical decisions were undertaken after discussions with the relevant lead for that specific area. We spoke with five 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.

We saw that the practice was regularly monitoring and reporting on quality and governance. For example, we saw that significant event and complaint figures were reviewed and monitored regularly. The practice used the Quality and Outcomes Framework (QOF) as a means to measure its performance. QOF data showed that the practice performance was in line with other practices nationally.

Clinical audits were undertaken by the practice. We were shown records of completed audits the practice had undertaken during the past three years. These included audits on prescribing medicines, end of life care and cervical screening. As a result of these improvements had been identified and implemented.

Leadership, openness and transparency

The practice had three GP partners who together with practice manager and business manager provided a stable leadership. Staff told us they were well supported by GPs and the practice manager who were always approachable, caring and open.

There was a leadership structure which had named members of staff in lead roles. Staff we spoke with were clear about their roles and responsibilities and knew who to go to for support.

Team meetings were held regularly, at least monthly. These meetings which included training on specific subjects were attended by all practice staff. 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.

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Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the national GP patient survey, their website, comments left on NHS Choices website and complaints process. For example we saw that the practice had responded to comments left on the NHS Choices website. Issues raised and learning points were discussed at clinical or other meetings as appropriate.

The practice had a virtual patient participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement. The practice website actively encourages patients to register to become members. The practice in conjunction with the PPG had conducted a practice survey in 2014. The report and the action plans following this survey were made available on the practice website. Priority areas for improvement included raising awareness of carers' issues and support, offering health checks and flu vaccination. The practice was currently working on improvements.

Are services well-led?

Good

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

The practice gathered feedback from staff through a variety of methods such as, staff meetings, appraisals and giving staff open access to the practice manager and GPs. Staff told us they were content to give feedback and discuss any concerns or issues with colleagues and management.

Staff told us they were aware of the whistle blowing procedure and would feel comfortable to implement it.

Management lead through learning and improvement

The practice provided staff with opportunities to continuously learn and develop. Practice nursing staff told us they had opportunities for continuous learning to enable them to retain their professional registration and develop the skills and competencies required for chronic disease management. Regular staff appraisals were taking place and personal development plans identified.

The practice had regularly reviewed significant events and other incidents with a view to identifying any trends or themes and learning opportunities. These events were shared with relevant staff as and when appropriate through team meetings.

The practice is an accredited training practice with the East of England Deanery to teach medical students and qualified doctors to become GPs. We found that the practice provided appropriate supervision for these trainees.