Dr K Hodge and Partners

Quality Report

Fernville Surgery
Midland Road
Hemel Hempstead
HP2 5BL
Tel: 01442 213919
Website: fernvillesurgery.org

Date of inspection visit: 29 April 2015
Date of publication: 16/07/2015

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr K Hodge and Partners on 29 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, 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 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.
- Policies and procedures were robust and embedded in the practice giving guidance to staff to carry out their roles.
- 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.
- Feedback from patient was positive. 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.
- Staff were supported with training and development.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There was an area of practice where the provider needs to make improvements.

The provider should:

Summary of findings

- Complete the actions highlighted from the recent infection control audit.

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. Significant events were discussed at staff meetings. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

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

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. Comment cards received indicated patients were happy with the service they were receiving with some staff mentioned by name for providing good care. 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. Improvements had been made to the telephone system making it easier for patients to contact the practice. Patients said they found it easy to make an appointment with urgent appointments available the same day. The practice had good facilities and was well

Summary of findings

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. There was evidence that learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There was an open door culture evident within the practice with staff commenting that all the partners were approachable for support. The practice had a number of policies and procedures to govern activity and held regular practice 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. The patient participation group (PPG) was active and had made recommendations that the practice responded positively to. Staff had received inductions, appraisals and attended staff meetings.

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. The practice visited three local care homes each week in addition to home visits as required.

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. There was a lead GP to support patients with diabetes. 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. A comprehensive recall system was in place to ensure these patients received their annual review. 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. Meetings were held with the health visitor to review children at risk. Immunisation rates were relatively high for all standard childhood immunisations. 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 and health visitors.

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. Appointments were available two evenings a week and every Saturday morning for those patients unable to attend during working hours. Telephone appointments were also available daily. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. They held a register of patients living in vulnerable circumstances including those with a learning disability. The practice pro-actively called patients with a learning disability for an annual health check with 81.5% of patients on the register receiving one in the last year. 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). 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 participated in the dementia diagnosis enhanced service and the on going screening and early recognition of dementia services.

There was a weekly Fernville Therapy Group, a support group for patients with long term problems that offers mutual support and was supervised by a local psychotherapist. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to provide us with feedback on the practice. We received 27 completed cards. All of these were positive about the practice and the service they received. Patients said the practice provided a caring and confidential service and they had been treated with dignity and respect. Many of the staff were mentioned by name for providing a good service to the patients. In addition to the positive comments, on three of the cards there were remarks on the length of time it can take for the patient to see their own GP.

We spoke with eight patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Positive comments were made about the reception staff being polite and helpful.

We spoke with the chair of the patient participation group who informed us that the practice responded well to suggestions made and acted on feedback given by the group.

The data from the National Patient Survey 2014 was reviewed. The practice scored well with 88% of respondents stating their overall experience of the practice was fairly good or very good and 83% of respondents stating the GP they last saw was good or very good at treating them with care and concern.

Areas for improvement

Action the service SHOULD take to improve

• Complete the actions highlighted from the recent infection control audit.

Dr K Hodge and Partners

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, a practice manager and a practice nurse acting as specialist advisors.

Background to Dr K Hodge and Partners

Dr K Hodge and Partners is also known as Fernville Surgery and provides a range of primary medical services to the residents of Hemel Hempstead. The practice population is of mixed ethnic background although predominantly English speaking. National data indicates that the area is one of lower deprivation. The practice has a list size of approximately 16200 patients which has been steadily increasing each year.

The practice is run by four GP partners, three male and one female and a non-clinical managing partner. They employ seven salaried GPs, one male and six female. There is also one nurse practitioner, two practice nurses and a health care assistant. The practice also has a number of reception and administration staff.

The practice is a training practice and currently has one trainee GP.

The practice has opted out of providing out-of- hours services. This service is 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 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 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 29 April 2015. During our visit we spoke with a range of staff including GPs, nursing staff, the managing partner, 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. After the inspection we spoke with the chairperson of the Patient Participation Group (PPG).

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Incident forms were available for staff to complete and forward to the managing partner. We saw that one of these had been used to identify an abusive patient and appropriate action had been taken.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. They showed a full investigation and outcome had been recorded for each event; lessons learned and appropriate actions taken were documented. Significant events was a standing item on the weekly practice meeting agenda. We saw from minutes of these meetings that any new significant events were discussed to review actions and learning. 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 used incident forms on the practice intranet and sent completed forms to the managing partner. They showed us the system used to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner. 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 managing partner to practice staff. Staff we spoke with informed us that alerts were sent to the relevant people.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of 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. The practice had policies in place for safeguarding children and adults which contained guidance on identifying and managing signs of abuse. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and another in safeguarding children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The practice kept a register of vulnerable adults and children and these were discussed at monthly primary health care team meetings attended by practice staff, health visitors and midwives. We saw from minutes that each case was discussed and information was shared between the practice and the primary health care team.

There was a system to highlight vulnerable patients on the practice's electronic records. GPs informed us they would enter the required code to ensure that information was flagged to practice staff. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and patients with caring responsibilities.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken

training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We saw that reception staff that had been trained to act as a chaperone had had a Disclosure and Barring (DBS) check.

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 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. We saw records that showed the fridge temperature was checked daily and staff were able to describe the actions they would take in the event of a failure.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw logs that showed the process was being followed and all the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support from a GP in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Reception staff had received training in the management of repeat prescriptions and they were able to describe the process they followed to ensure the prescription was still necessary and appropriate. Blank prescription forms were handled in accordance with national guidance; these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had identified a member of the nursing team as the lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out two infection control audits in the past year. The audits showed that elbow taps were required in the treatment rooms and this had been discussed at practice meetings. The practice informed us that they had planned to replace these taps but at the time of the inspection this had not been done. Since the inspection the practice manager had informed us the taps will be replaced by the 31 December 2015. Mitigating actions had been put in place to reduce the risk of infection until the taps had been replaced which included the use of paper hand towels to turn off the taps.

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. 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.

The practice had completed a risk assessment and had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

We saw the practice had equipment to enable them to carry out diagnostic examinations, assessments and treatments. All the 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, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

We looked at the records of five staff members and found they all 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 documented recruitment process that set out the standards it followed when recruiting clinical and non-clinical staff. This included reference to the equal opportunities policy to ensure fairness and obtaining Disclosure and Barring Service (DBS) checks for all clinical staff and non-clinical staff with patient contact. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and unplanned absence including sick leave. Only one member from each staff group was allowed annual leave at a time.

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. We were informed that there was a vacancy for a patient services manager but other administrative staff had been given development opportunities to take on aspects of this role to ensure the smooth running of the practice.

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.

There was no formal risk log but the practice had identified risks and mitigating actions within their policies and procedures. We saw that any risks were discussed at the weekly partners meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We saw minutes from the practice meeting that showed a significant event regarding a seriously ill patient who had attended the practice and required an ambulance. Actions had been put in place as a result of this incident to ensure all staff received training in their induction to deal with such an event.

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. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. There was also a box containing equipment that may be required in the event of an emergency for example reflective jackets, a hard hat and torches. A copy of the plan was kept off site by the managing partner. 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.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The fire alarms were checked weekly and records showed that staff were up to date with fire training and that they practised regular fire drills. The practice had named fire marshals to assist others in the event of a fire.

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, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs told us that any new guidelines were discussed at practice meetings. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, dermatology, gynaecology and family planning. We were informed that one of the GPs was a specialist in deep contraceptive implant removal and took referrals for this service from other practices in the locality. Contraceptive implants provide hormones under the skin to prevent pregnancy. The practice nurses supported the work of the GPs and were trained to manage patients with long term conditions such as chronic obstructive pulmonary disease and diabetes. One of the GPs led in the care of patients requiring complex diabetes management. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We saw data from the local CCG of the practice's performance for antibiotic prescribing. This data, and the national data available to the CQC, showed that the practice was similar to other local practices in its antibiotic prescribing rates. The practice reviewed patients with chronic diseases in line with the requirements of 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. The QOF data showed they were achieving targets in line with other practices within the local CCG. Patients with complex needs had multidisciplinary care plans documented in their case notes and were discussed at multi-disciplinary team meetings. We were shown the process the practice used to review patients recently discharged from hospital. This required the discharge summary from the hospital to be reviewed and the patient seen by their GP according to need.

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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the senior administration staff to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last two years. One of these was a review of patients with peripheral artery disease, a condition in which a build-up of fatty deposits in the arteries restricts blood supply to leg muscles, and recommendations for future treatments had been made. Another example was an audit to confirm that the GPs managed patients with irritable bowel syndrome according to NICE guidelines. We saw that a second audit had been completed that showed the practice continued to manage these patients according to the guidelines.

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). For example, we saw an audit regarding the prescribing of a specific antibiotic which ensured that the prescribing of this medication was in line with the local CCG guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease. This practice was not an outlier for any QOF clinical targets.

Good

Are services effective?

(for example, treatment is effective)

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The clinical system flagged up relevant medicines alerts when the GP was prescribing medicines. 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 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. These meetings were attended by Macmillan nurses, health visitors and district nurses.

The practice participated in the dementia diagnosis enhanced service and the ongoing screening and early recognition of dementia services. This helped to facilitate timely diagnosis and support for people with dementia.

There was a weekly Fernville Therapy Group, that took place at the practice. This was a support group for patients with long term problems that offered mutual support and was supervised by a local psychotherapist.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

The GP partners informed us they held additional roles within the local area for example one of the partners was a CCG board member and Urgent Care Lead working with the local NHS 111 service and OOH provider to improve services for patients.

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.

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 one of the practice nurses informed us that their training needs were assessed on employment with the practice and training courses were scheduled for the following six months to enable her to carry out her role.

The practice was a training practice and had a culture of education and learning. The practice trained medical students, doctors who have just qualified from medical school and those who are undertaking additional training to become a GP. The practice also had sixth form students attend for work experience.

The practice employed a nurse practitioner, practice nurses and a healthcare assistant who 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 ear syringing. Those with extended roles included seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles. The nursing staff informed us they have weekly clinical supervision meetings to enable them to reflect on their practice.

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 NHS 111 service both electronically and by post. The practice had a

policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

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). We saw that the policy for acting on hospital communications was working well in this respect.

The practice held multidisciplinary team meetings each month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses 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 used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through 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.

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, 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.

The practice had a consent and capacity assessment policy which included guidance on Gillick competencies to assist staff assess if a patient had capacity to make a decision. 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.

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 and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

The practice offered a health check for all new patients with the health care assistant. The GP was informed of all health concerns detected and these were followed up in a timely way. GPs informed us they used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

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. There were 103 patients on the register and all of them were offered an annual physical health check. Practice records showed 84 check-ups had been carried out in the last 12 months, this equated to 81.5% of patients on the register. The practice achieved this by pro-actively making an appointment with the practice nurse for these patients and sending them a letter with the appointment date and time. The practice had also identified the smoking status of 82% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Appointments for these clinics were available up to 8pm twice a week to enable those patients working in the day to attend. The nurses encouraged the use of a smart phone app, a computer

Good

Are services effective?

(for example, treatment is effective)

program on the patients mobile phone, to aid patients to stop smoking. There was evidence these were having some success as the number of patients who had stopped smoking after 12 weeks was 58%. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical cytology uptake was 77%, which was comparable to others in the CCG area. There was a policy to offer reminder letters for patients who did not attend for cervical cytology.

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 average for the CCG, and again there was a clear policy for following up non-attenders by the practice nurse.

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 2014. The evidence from this survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated comparable to the national average with 88% of patients who rated the overall experience of their GP practice as fairly good or very good. The practice was also above average for its satisfaction scores on consultations with doctors with 92% of practice respondents saying the GP was good at listening to them and 88% saying the GP gave them enough time.

The nursing staff also scored well with 94% of respondents stating they had confidence and trust in the last nurse they saw. However the nurses scored less well with 78% of respondents stating that the last nurse they saw was good at treating them with care and concern which was below the local CCG average. We saw that the practice had looked at this result and discussed it at a meeting with the nursing team and the GP partners. The GP partners were satisfied from their own observations and peer reviews that the nurses were treating the patients with care and concern. On the day of the inspection we saw staff were polite and professional when speaking with patients and colleagues.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and all of these were positive about the service experienced. Patients said they felt the practice offered an excellent, caring service and staff were friendly and helpful. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Positive comments were made about the reception staff being polite and helpful.

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 / 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. The practice had installed a call handling room away from reception which was manned by reception staff. This helped keep patient information private when they contacted the practice via the telephone. The reception desk was shielded by glass this prevented patients overhearing potentially private conversations between patients and reception staff. The patient waiting area was visible to the receptionists but away from the front desk this again helped to maintain confidentiality. There was also an electronic check in system, available in different languages, for patients to bypass the reception desk.

The practice charter was displayed in the patient reception area. This contained a paragraph 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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey 2014 showed 81% 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 average compared to the local clinical commissioning group (CCG) area.

Patients we spoke with on the day of our inspection told us that the GPs gave good explanations about their care and treatment and they were given enough time to discuss their health issues. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. The practice also used a signing language service for those patients who had hearing difficulties.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. These included Age UK and Macmillan Cancer Support. The practice's computer system alerted GPs if a patient was also a carer. The practice had a carers' pack that it gave to these patients, this contained information of the support available to them and a referral form for Carers in Hertfordshire. This organisation provided relevant information and advice, local support services, a newsletter and a telephone link.

The patients we spoke with on the day of our inspection and the comment cards we received were consistent in highlighting that staff responded compassionately when they needed help and provided support when required.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was followed by a patient consultation if required. Information on support available following a bereavement was available in the patient waiting room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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). The practice set up a call handling room to take calls from patients away from the reception area which helped to maintain patient confidentiality. This also helped to improve access to the service with an increase of calls answered within one minute from 20% in 2013 to 43% in 2014. Also in response to feedback from the PPG the practice increased the availability of same day appointments, this included five minute urgent appointments and telephone consultations.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice registered patients with no fixed abode using the practice address as the patients' address so the homeless could access healthcare services. The practice also registered patients from a local traveller's site as permanent patients.

The practice had access to translation services for patients for whom English was not their first language and a signing language service for those with hearing difficulties.

The practice provided equality and diversity training. We saw from the practice training records that this training had been completed by staff in the last 12 months. Staff we spoke with confirmed that they had completed the equality and diversity training.

The premises and services had been adapted to meet the needs of patient with disabilities. There was a ramp outside for wheelchair users to gain access to the practice and double doors at the entrance. The PPG informed us that on their recommendation the practice had applied for funding to install automatic doors. All the corridors and doors were wide enabling wheelchair users to navigate the building independently and the patient waiting area was large enough to accommodate wheelchairs, prams and pushchairs. The practice had consulting rooms on the ground and first floors; staff informed us that patients who had difficulty using the stairs would be seen in a downstairs consulting room. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8am to 6.30pm on weekdays and evening appointments until 8pm were available on Tuesdays and Thursdays. The practice also opened from 8am to 12pm on Saturday mornings for pre-bookable appointments.

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 was information available for which conditions were appropriate to book an appointment with a member of the nursing team and how long the appointment should last. 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 advised them to ring NHS 111 to access the out-of-hours service provided to patients.

Longer appointments were 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 three local care homes on a specific day each week, by a GP and on request to those patients who needed one. The practice scheduled a GP to complete home visits each morning, rather than waiting until later in the day, this enabled patients who required a hospital referral earlier admission and treatment.

Comments from patients on the day of the inspection and some of the comment cards indicated that they sometimes had to wait for a routine appointment but most patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to.

The practice reviewed their capacity each week by looking at how long patients had to wait to book a routine appointment. If necessary extra appointments were made available; the practice would use a locum GP to accommodate this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice's extended opening hours on Tuesday and Thursday evenings and Saturday mornings was particularly useful to patients with work commitments and those of school age.

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.

Information was available to help patients understand the complaints system in the practice leaflet. This was available from the practice and electronically on the practice website.

We looked at 23 complaints received in the last 12 months and found complaints had been handled satisfactorily with clear responses given to patients. Apologies had been given when required. One complaint had been made to the Ombudsman and we saw that the practice had shared requested information with them.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. Representatives from each staff group attended the complaints review meetings and shared any learning with their colleagues.

We saw that as a result of a complaint the nursing staff reviewed all their appointments booked online so that patients who had inappropriately booked an appointment to see a nurse could be contacted and the appointment rearranged with the correct practitioner.

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 practice charter that was available on the website and was displayed in the reception area for patients and staff to view. The charter contained the practice values which included treating patients equally and without discrimination with access to services prioritised on clinical need. The charter also stated that staff would always treat patients with respect and dignity.

We spoke with eleven members of staff and they all knew and understood the values and knew what their responsibilities were in relation to these. Throughout the visit we saw staff treating patients in a kind and caring way.

The practice informed us of their plans to federate with other GP practices in the locality area. The aim of this was to sustain local health services. The managing partner had worked as the project manager for the planning of a local GP Lead Health Centre.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All staff we spoke to knew how to access the policies and procedures. We looked at eight of these policies and procedures and found they were up to date and reviewed every one to two years.

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 a GP was the lead for safeguarding. We spoke with eleven members of staff and they were all clear about their own roles and responsibilities. The staff members informed us of an open culture within the practice and they all felt able to talk to the partners to raise any concerns. Throughout the inspection it was evident that staff were supportive of each other with a strong team ethos.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we saw an audit of patients with peripheral artery disease and how improvements had been made with changes to medication and smoking cessation advice.

The practice had arrangements for identifying, recording and managing risks. Risks and mitigating actions were documented within the policies and procedures. We saw from minutes of meetings that risks were discussed and learning shared within the practice.

Leadership, openness and transparency

Staff informed us that the managing partner held team meetings over a period of three days per month in order to give all staff the opportunity to attend regardless of their work pattern. 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.

The managing partner and a senior member of the administration team were responsible for human resource policies and procedures. We reviewed a number of policies, for example the equal opportunities policy, the recruitment policy and the induction plan for new staff members which were in place to support staff. 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 surveys, the patient participation group (PPG) and complaints received. We saw that the practice had made improvements to their telephone system and recruited additional reception staff in response to a survey carried out in 2013 to 2014. This resulted in calls being answered sooner and an improved service for patients. The practice had also introduced telephone consultations and urgent on the day appointments to improve access. In response to recommendations of the PPG the practice had applied for funding to install automatic doors at the entrance to the practice to improve access to the building.

The practice had an active PPG which met approximately every two months. All new patients to the practice are informed of the PPG and invited to express an interest in joining the group. The PPG has a carer's lead who attended the flu clinic in an attempt to recruit carers to the group.

Are services well-led?

Good

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

The practice had gathered feedback from staff through appraisals and staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that there was a culture of training and learning in the practice.

The practice was a GP training practice and had three GP trainers. They trained medical students, newly qualified doctors and GP registrars who are doctors undergoing additional training to become a GP. The practice informed us the GP registrars were included in practice meetings including partners meetings so they gained an understanding of the management of a practice.

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. We looked at minutes of meetings that confirmed this.