Ephedra Healthcare

Quality Report

Spring House Medical Centre
Ascots Lane
Welwyn Garden City
Hertfordshire
AL7 4HL
Tel: 01707294354
Website: www.springhouse.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ephedra Healthcare on 11 June 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, people whose circumstances make them vulnerable, families, children and young people, working people and those who have recently retired and people experiencing poor mental health

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- 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.
- The practice had policies and procedures in place to govern its activities.
- The practice was carrying out clinical audits to help them monitor and improve the quality of care given.
- 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.
- 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.

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

Importantly the provider should

Summary of findings

- Implement plans for a patient participation group (PPG) to seek feedback and views about the practice from their patients.

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. The practice had very good safeguarding procedures in place to protect children and vulnerable adults.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were comparable to others in the locality and we saw that the practice had worked to improve positive outcomes for patients in areas that needed improvements. 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. The practice was pro-active in providing training and all staff had received training appropriate to their roles. 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. Data showed that patients rated the practice higher than others for several aspects of care. 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. The practice had a carers' champion and provided information on support services. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice worked with a local community group to provide food vouchers to those patients that needed them to use at the food bank.

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. Patients were happy with the practices opening hours and said they

Summary of findings

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. Health promotion leaflets were available in many languages for patients who did not speak English. 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. There was a mix of male and female GPs and all staff had received equality and diversity training in the past 12 months.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. The vision was on display at various points around the practice. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice used feedback from staff and patients to help improve services. They didn't have a patient participation group (PPG) but plans were in place to implement one in the near future. Staff had received inductions, regular performance reviews 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 had a lower than average number of older people registered with them but offered proactive, personalised care to meet their needs and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. The practice had increased their number of diabetic clinics to improve the care and outcomes for these patients.

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. Appointments were available outside of school hours and the premises were suitable for children and babies. A visiting midwife had a weekly clinic which had recently been lengthened due to the higher than average number of patients in this group.

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. The practice was proactive in offering online services as well as

Summary of findings

a full range of health promotion and screening that reflects the needs for this age group. The opening hours of the practice from 8am to 8pm seven days a week allowed for easy access for patients working during normal office hours.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. 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. There was a safeguarding lead who had implemented appropriate safeguarding procedures. Homeless patients could use the practice address as their home address to allow them better access to services.

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.

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 39 completed cards and without exception they were all positive about the service experienced. The reception staff had been identified as being friendly and helpful. There were also comments about the GPs and nurses being professional and providing good care.

We spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said they were treated with respect. They also commented on how friendly and helpful the staff were. Patients who had used the walk in service commented on its usefulness when they had been unable to obtain an appointment with their own GP.

The data from the National Patient Survey 2014 was reviewed. The practice scored well with 89% of respondents describing the overall experience of the practice as good.

Areas for improvement

Action the service SHOULD take to improve

Implement plans for a patient participation group (PPG) to seek feedback and views about the practice from their patients.

Ephedra Healthcare

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a practice manager acting as specialist advisors.

Background to Ephedra Healthcare

Ephedra Healthcare is an organisation founded in 2009 to run a GP practice and GP led walk in centre called Spring House Medical Centre. They provide a range of primary medical services to the residents of Welwyn Garden City.

The practice population is of mixed ethnic background and national data indicates that the area is one lower deprivation. They have a lower than average older population and a higher younger population. The practice has approximately 7200 registered patients and provides services under a primary medical services contract (PMS). In addition to this the practice sees approximately 20,000 walk in patients per year. From July 2015 the walk in services will no longer be provided by the practice. Walk in patients will be seen at an Urgent Care Centre located at the QEII Hospital in Welwyn Garden City.

Ephedra Healthcare is led by six directors consisting of four clinicians and two practice managers. To run Spring House Medical Centre they employ a full time practice manager and eight salaried GPs, two male and six female. They also have a nursing team consisting of one nurse manager, two nurse practitioners and two health care assistants. The practice also employs a number of reception and administration staff.

The practice is open between 8am and 8pm Monday to Sunday with appointments available during these times. When they are 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 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?

Detailed findings

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 inspection on 11 June 2015. During our inspection we spoke with a range of staff including the practice manager, GPs, 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.

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. We reviewed records of 14 significant events that had occurred during the last year and saw this system was followed appropriately. Any new significant events were discussed at the clinical meetings and a dedicated meeting was held annually to review actions from past significant events and complaints. All new cancer diagnosis were logged as a significant event and reviewed at the significant events meetings. 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.

Incidents and significant events were logged on a hard copy form and sent to the practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked some 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 an error made when referring a patient to the local hospital in an emergency. We saw that this had been investigated and the information pack for clinical staff had been updated with the correct process to follow. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to practice staff. Any alerts that were appropriate were discussed at staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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. 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. They were able to give an example of how the reception staff had identified a safeguarding concern and how it was escalated to the safeguarding lead and a referral made to the local authority.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. 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.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. As the practice incorporated a walk in centre extra measures were implemented to ensure the safeguarding of children and vulnerable adults. This included safeguarding as a standing item on the monthly clinical meeting's agenda. The practice also liaised with other practices in the area and was sent a monthly update of the local child protection lists. These were stored on the practice computer system and all staff were trained to access and refer to these during consultations. The practice also appointed a senior receptionist to act as an administration lead for child protection. Their role included

monitoring all walk-in patients to see if they were on the child protection register and if so, they would alert the child protection lead of this. They also did an audit every month of patients under the age of 16 years attending the practice as a walk-in patient to identify any frequent visits; again these were escalated to the child protection lead. Details of all consultations for walk-in patients were e-mailed to their own GP.

There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors, community nurses and the local authority. The community health care team were invited to the monthly clinical meetings to discuss cases on the child protection register.

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. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. 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.

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 policy 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.

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. A stock list of all drugs held was kept and up to date.

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. All blank prescriptions were removed from consulting rooms at the end of the day and kept in a secure location.

The practice had a prescribing lead GP who attended the local clinical commissioning group (CCG) prescribing meetings then disseminated information to the clinical staff.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

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 sets of PGDs that had been updated in September 2014. We saw evidence that the nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

All three members of the nursing staff were qualified as independent prescribers and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed from the practice prescribing lead. One of the nurses had also recently set up a nurse prescribing forum within the locality which acted to provide clinical supervision for the nurse prescribers within the area. Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect on their practice. The meetings were planned bi-monthly to coincide with the CCG prescribing meetings so updates and changes could be discussed with the group.

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.

Good

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. We saw that all staff had signed a cover sheet to say they had read and understood the policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The nurse manager was appointed the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had an audit schedule in place to carry out infection control audits and an annual infection prevention and control risk assessment. We reviewed a recent audit and saw that identified actions had been completed.

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 segregated its waste into clinical and non-clinical. We saw that it was stored appropriately and collected on a regular basis.

They had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).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

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was September 2014. A schedule of testing was in place.

We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer had all been calibrated in September 2014.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical 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 the appropriate checks through the Disclosure and Barring Service. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice manager informed us that staffing levels were reviewed each week with staffing rotas made six weeks in advance. This ensured the correct number and mix of staff needed to meet patients' needs. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. They also had a health and safety policy. Health and safety information was displayed for staff to see and the practice had identified two members of staff to act as health and safety representatives.

Identified risks were monitored though individual assessments for example infection control, fire risk and health and safety. Each risk was assessed and mitigating actions recorded to reduce and manage the risk.

Good

Are services safe?

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 in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff 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. The document also contained relevant contact details for staff to refer to. For example, details of a heating company to contact if the heating system failed. The plan was last reviewed in May 2015.

The practice had carried out a fire risk assessment in March 2015 that included actions required to maintain fire safety. The fire escapes were clearly signposted and the fire alarm was tested weekly. The practice had an identified fire marshall and records showed that staff were up to date with fire training. They practised regular fire drills; the last one was documented as done in April 2015.

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. Guidelines were accessible in all the clinical and consulting rooms. New guidelines were downloaded from the website and disseminated to staff. They were also discussed at clinical meetings. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

The practice had lead GPs for diabetes, prescribing and safeguarding. The practice nurses reviewed patients with long term conditions such as diabetes, heart disease and asthma. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Clinical meetings were held monthly on different days to allow optimum attendance by staff. Minutes of the meetings were emailed to all GPs and nurses.

One of the GPs and the nurse manager had attended an Ebola training session and cascaded the information to the rest of the staff.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. All of the patients identified had multidisciplinary care plans documented in their records which were reviewed regularly to ensure that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital a further review of the care plan was done to see that all their needs were continuing to be met.

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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us 12 clinical audits that had been undertaken recently. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example the practice had reviewed it's prescribing of certain antibiotics. Data showed the practice had a higher than average prescribing rate for antibiotics which could be attributed to the amount of walk in patients seen. The second audit showed that there had been some changes made and actions identified for continued improvements. A further re-audit was planned for October 2015. Other examples included audits to confirm that the GPs who undertook minor surgical procedures, were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was an outlier in some areas for example patients over 65 receiving a flu vaccination and the reported prevalence of coronary heart disease. The GPs offered a

Good

Are services effective?

(for example, treatment is effective)

potential explanation for this as the patient demographic with low numbers of patients over the age of 65 registered with the practice. The practice had been below average for the care and treatment of patients with diabetes. The diabetic lead had worked with the nursing team to address this by providing additional diabetic clinics including once a month on a Sunday morning.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had made use of the gold standards framework for end of life care. It 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. The practice did not routinely have many palliative care patients due to the lower age range of its practice population.

Structured annual reviews were undertaken for people with long term conditions for example diabetes and chronic obstructive pulmonary disease (COPD) as well as vulnerable patients such as those with learning disabilities. We were informed that all of these had been carried out in the last year.

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 have 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. The practice was proactive in providing training and funding for relevant courses, for example the nurses had completed independent prescribing courses.

The nurses and health care assistants had defined roles and responsibilities and were able to demonstrate that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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. Out-of hours reports, NHS 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and acted on on the day of receipt and all within five days of receipt. 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.

Emergency hospital admission rates for the practice were relatively low at 7% compared to the national average of 14%. The practice was commissioned for the unplanned admissions 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 monthly to discuss patients with complex needs. For example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and health visitors. Decisions about care

Good

Are services effective?

(for example, treatment is effective)

planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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.

A record of consultations of patients that attended the walk in service was sent to the patient's own GP to inform them of the visit and any investigations carried out or medications prescribed.

The practice had signed up to the electronic Summary Care Record. This provides 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.

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.

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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. This is used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. The practice had completed an audit of minor surgical procedures from April 2014 to May 2015, this confirmed the consent process had been followed in 100% of cases.

Health promotion and prevention

The practice offered a health check to all new patients registering with the practice and NHS Health Checks to all its patients aged 40 to 74 years. These were completed by the health care assistant and a GP was informed of all health concerns detected and these were followed up in a timely way. The GPs and nurses 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 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 89% of patients over the age of 16. This was comparable to the CCG and national performance of 86%. The health care assistant had been trained to give smoking cessation advice and had a clinic one evening a week from 5-8pm for these patients. Ninety-five percent of patients identified as smokers had been offered advice. 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 the cervical screening programme was 79%, which was similar to the national average of 82%. The nurses had worked to increase this percentage which was only 60% in 2014. They achieved this by utilising additional administration support to send letters to the patients in addition to the recall letters sent by the CCG. Three additional letters were sent and a telephone reminder to advise patients to attend for a cervical screening test. The nurses informed us that they

Good

Are services effective?

(for example, treatment is effective)

had been educating patients who had moved to the area from abroad and opportunistically reminding patients of the need for screening when they were visiting the practice for other issues.

The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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 was average or slightly below for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 61%, and at risk groups 52%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 89% to 93% and five year olds from 85% to 91%. These were slightly below the CCG average.

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, and the practice patient survey report 2014 which had a total of 103 returned questionnaires.

The evidence from all these sources 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 above average with 93% of respondents saying their overall experience of the practice was good. The practice was also above average for most of its satisfaction scores on consultations with doctors and nurses. For example:

- 90% said the GP was good at listening to them compared to the CCG average of 86% and national average of 87%.
- 86% said the GP gave them enough time compared to the CCG average of 84% and national average of 85%.
- 90% said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and national average of 92%
- 84% said the nurse was good at listening to them compared to the CCG average of 80% and national average of 79%.
- 83% said the nurse gave them enough time compared to the CCG average of 78% and national average of 80%.
- 87% said they had confidence and trust in the last nurse they saw compared to the CCG average of 84% and national average of 86%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 39 completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent and professional service. They commented that the staff were efficient, helpful, friendly and polite and treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said they were treated with respect. They also commented on how friendly and helpful the staff were.

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. We saw that a risk assessment had been done in relation to maintaining confidentiality in the reception area as the reception desk was open and close to the waiting area. We saw that staff were aware of this and followed the recommended steps to maintain confidentiality for example they had music playing to act as a distraction and when speaking on the telephone they never repeated the patient's details aloud. If a patient wanted to speak in private they were taken to a separate room. Additionally, 92% said they found the receptionists at the practice helpful compared to the CCG average of 83% and national average of 87%.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 for most areas rated the practice well. For example:

- 75% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 71% and national average of 75%.
- 78% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 74% and national average of 77%.

72% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 63% and national average of 66%.

Good

Are services caring?

They were slightly below average in one area as 75% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and national average of 82%.

Patients we spoke with on the day of our inspection and the comments cards we received were also positive and aligned with these views.

The practice used a translation service for patients who did not have English as a first language. The contact number for this was available in the consultation rooms. Longer appointments were available for patients requiring translation services. There was a function on the practice website to translate the information into a number of different languages and many of the health information leaflets in the waiting area were available in different languages. The practice also used a type talk service for patients who were hard of hearing and there was a hearing loop in the reception area.

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 and rated it well in this area. For example:

- 80% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 83%.
- 77% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 75% and national average of 78%.

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

Notices in the patient waiting room and the practice website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified a member of staff as a carers' lead and there was a display of useful information in the waiting area that carers could read and take away. This included information for carers to ensure they understood the various avenues of support available to them.

The practice worked with a local community group to provide food bank vouchers to patients that needed extra support. The GPs assessed the patients' needs and a voucher was issued to be redeemed at a community group food bank.

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. This enabled the practice to operate a walk in service in addition to the GP services.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw that the practice communicated well with other practices in the area with regards to patients using the walk in services and shared information regarding safeguarding and consultations.

Although the practice had had a patient participation group (PPG) in the past, the group was not active at the time of the inspection. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice manager informed us that they had been consulting with other practices in the locality to gain information on starting a group and planned for this to be active in the near future.

The practice used the NHS friends and family test to gauge patient satisfaction with the service provided. The friends and family test was introduced in GP practices in December 2014 and gave patients the opportunity to give quick feedback on the quality of the care they received.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, or long term conditions and those with carers. New patients attending the practice were able to register with a GP and be seen on the same day. The practice population was of mixed ethnicity and access to a telephone translation service was available for patients who did not speak English.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. There were ramps and wide doors for wheelchair users at the entrance and all the fire exits. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. The waiting area had enough space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

The practice had several homeless patients who used the practice address as their home address to allow them better access to services. There was a system for flagging vulnerability in individual patient records.

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

We saw from the training records that all staff had received Equality and Diversity training in the past 12 months.

Access to the service

The surgery was open from 8am to 8pm every day including weekends. Appointments were available during these times. Patients not registered with the practice could use the walk in service and would be seen if they arrived at the practice before 7.30pm. Registered patients could also use the walk in service if no pre bookable appointments were available and would be seen if they arrived at the practice before 8pm. The practice will not operate a walk in service for unregistered patients from July 2015. Walk in patients will be seen at an Urgent Care Centre located at the QEII Hospital in Welwyn Garden City from this date.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments 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.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 90% were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 76%.
- 79% described their experience of making an appointment as good compared to the CCG average of 66% and national average of 74%.
- 68% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.
- 92% said they could get through easily to the surgery by phone compared to the CCG average of 62% and national average of 72%.

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. We also spoke to unregistered patients using the walk in service and they also expressed satisfaction with being able to see a GP. Routine appointments were available for booking six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice or had been able to obtain a walk in appointment. Home visits were available for those patients who were unable to attend the practice.

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 for example on the practice website and in the patient information leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found they had been satisfactorily handled and dealt with in a timely way with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review, 18 complaints had been documented and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. Staffing levels had been reviewed in response to one complaint. We saw that learning from complaints had been shared with staff.

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 an exceptional standard of care. We saw the practice values were clearly displayed on the front entrance door, on notice boards throughout the practice and in the practice booklet. They were also on a large display behind the reception desk visible to patients in the waiting area. The practice vision and values included how the practice prided itself on treating everyone fairly and equally and the staff strived to offer a warm, friendly and professional service.

We spoke with nine members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of these policies and procedures and noted they were appropriate and in date. Staff had completed a cover sheet to confirm that they had read the policy and when.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a nurse who was the lead for infection control and a GP was the lead for safeguarding. There was also a lead GP for prescribing and a dementia champion. All the staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. The practice manager met with the directors weekly to discuss the management of the practice.

The practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. These included using the Quality and Outcomes Framework to measure its performance. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. 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 also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we saw audits relating to the prescribing of antibiotics and minor surgery. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example a confidentiality risk assessment of the reception area and the whole practice and a health and safety risk assessment.

The practice manager was responsible for human resource policies and procedures and used the services of an external company for guidance. We reviewed a number of policies, including disciplinary procedures, management of sickness and the recruitment policy which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equal opportunities and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

Staff told us there was an open culture within the practice. They said the practice manager and the GPs were approachable and always take the time to listen to all members of staff.

The practice had regular team meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients surveys and complaints received. The practice also kept a record of compliments received which were all acknowledged and if a staff member was mentioned by name a copy was kept for reference on their HR file. The practice had had a

Are services well-led?

Good

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

patient participation group (PPG) in the past but it was not active at the time of the inspection. The practice manager informed us that they wanted to start a new group and would be seeking membership from the patients.

The practice had also gathered feedback from staff through staff meetings, discussions and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the practice manager.

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. We saw that training was encouraged and offered for all staff for example one of the nurses had recently completed a prescribing course. Staff confirmed that the practice was very supportive of training.

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 from meetings which confirmed this.