

Peartree Surgery

Quality Report

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

Ratings

Overall rating for this service

Inadequate



Are services safe?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Requires improvement



Are services well-led?

Inadequate



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Peartree Surgery on 19 October 2016. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because systems and processes in place were not adequate to ensure patients received the required checks before being prescribed high risk medicines. The management of clinical records from secondary care services was ineffective.
- The system in place for identifying and recording significant events was not effective.
- The practice had insufficient clinical leadership capacity and not all governance structures, systems and processes were effective and enabled the provider to identify, assess and mitigate risks to patients, staff and others.
- Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. However, the system and process to identify staff learning needs was not effective.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- 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, however the provider did not follow their complaints procedure when responding to complaints.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

The areas where the provider must make improvements are:

- Ensure the systems and processes are in place for safe prescribing of medicines, including high risk medicines, and the timely management of clinical records received into the practice, including secondary care clinical notifications and pathology results.
- Ensure systems are implemented to enable staff learning needs to be identified through a system of staff appraisals.
- Ensure completion and effective management of the actions identified in the Legionella risk assessment.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure processes are improved to enable effective communication.

The areas where the provider should make improvements are:

- Review the process for identifying and recording significant events and complete a periodic review of significant events to identify trends.
- Include information on the Parliamentary Health Service Ombudsman when formally responding to complaints.
- Continue to review and monitor the National GP Patient Survey results to ensure improvement.

- Review and make improvements disabled patient toilet facilities provided in line with the requirements of the Equality Act 2010.
- Ensure an appropriate system is in place for the safe monitoring of blank prescriptions.
- Continue to monitor infection prevention and control through audits across all premises.
- Review the business continuity plan and ensure it meets current circumstances.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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?

The practice is rated as inadequate for providing safe services.

- We found evidence that patients were at risk of harm because the systems and processes in place to ensure patients had received the required checks before being prescribed high risk medicines were inadequate.
- The practice did not have an effective system in place to identify and record significant events and did not analyse significant events over time to identify trends.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. However, the practice had never completed an infection control audit.
- Blank prescription forms and pads were securely stored however there was no system in place to monitor their use.
- The practice's business continuity plan had been reviewed in April 2016 however the emergency contact list for staff members was not up to date.
- We found the practice had not responded to the requirements identified following an assessment of Legionella which was undertaken in March 2015.
- When there were unintended or unexpected safety incidents, patients received support and a verbal and written apology.

Inadequate



Are services effective?

The practice is rated as requires improvement for providing effective services.

- We found the systems in place for the safe management of clinical records from secondary care services to be insufficient.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable with or above average compared to local and national averages.
- The practice did not have effective systems and processes in place to identify staff learning needs. Staff appraisals weren't being carried out on a regular basis.
- Clinical audits demonstrated quality improvement.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- The practice offered flexible appointment times based on individual needs.
- 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.
- Staff maintained patient and information confidentiality and patients commented on being treated with kindness and respect.
- The practice held a register of carers with 467 carers identified which was approximately 2% of the practice list. The practice made information about local support groups and services available to patients in the waiting areas.

Are services responsive to people's needs?

The practice is rated as requires improvement for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and East and North Hertfordshire Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a system in place for handling complaints and concerns. However, the practice did not provide complainants with information about the Parliamentary and Health Service Ombudsman when responding to complaints.
- Data from the National GP Patient Survey results published in July 2016 showed patients rated the practice as below average for several areas including access to the surgery by telephone. The practice was aware of these results and were in the process of changing their telephone system.
- The practice had launched a new website in October 2016 which included a GP webpage portal which enabled patients to contact a GP on line and receive a response via e-mail within 72 hours.

Requires improvement



Are services well-led?

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

- The practice lacked systems and processes to operate effectively and safely and to ensure good governance.

Inadequate



Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings. However, not all governance structures, systems and processes were effective in enabling the provider to identify, assess and mitigate risks to patients, staff and others.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with permanent staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing effective and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population, this included enhanced services for avoiding unplanned admissions to hospital and end of life care.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments when required.
- Named GPs carried out a weekly visit to three local care homes. We spoke to a manager at each care home and they told us the practice provided a good service. They described the practice as accessible and responsive to needs of their residents and were positive about all aspects of the services provided by the practice.
- The practice provided health checks for patients aged over 75 years and had completed 1,025 health checks since September 2014, which was 63% of this population group.

Inadequate



People with long term conditions

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing effective and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- The nurse practitioner had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification within the preceding 12 months was 86%, which was comparable with the CCG average of 89% and national average of 88%.
- 88% of patients diagnosed with asthma, on the register, had received an asthma review in the last 12 months which was above the CCG average of 74% and national average of 75%.
- Longer appointments and home visits were available when needed.

Inadequate



Summary of findings

- All patients with a long-term condition had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing effective and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and identified as being at possible risk, for example, children and young people who had a high number of A&E attendances.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 83% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered a range of family planning services. Baby vaccination clinics and ante-natal clinics were held at the practice on a regular basis. A community midwife held a clinic at the practice on a weekly basis.

Inadequate



Working age people (including those recently retired and students)

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing effective and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- 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 carried out routine NHS health checks for patients aged 40-74 years.

Inadequate



Summary of findings

- The practice was proactive in offering on line services such as appointment booking, an appointment reminder text messaging service and repeat prescriptions, as well as a full range of health promotion and screening that reflects the needs of this age group.
- The practice had launched a new website in October 2016 which included a GP webpage portal which enabled patients to contact a GP and receive a response via e-mail within 72 hours.
- The practice provided an electronic prescribing service (EPS) which enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.

People whose circumstances may make them vulnerable

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing effective and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and had completed 14 health checks out of 101 patients on the learning disability register since April 2016.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Vulnerable patients had been told how to access various support groups and voluntary organisations.
- The practice had a system in place to identify patients with a known disability.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, records of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice held a register of carers with 467 carers identified which was approximately 2% of the practice list. The practice made information about local support groups and services available to patients in the waiting areas.

Inadequate



People experiencing poor mental health (including people with dementia)

The practice is rated as inadequate for providing safe and well-led services and requires improvement for providing effective and responsive services. The issues identified as inadequate and requiring improvement affected all patients including this population group.

Inadequate



Summary of findings

- 72% of patients diagnosed with dementia had their care reviewed in a face to face meeting in 2014/2015, which was below the CCG average of 86% and national average of 84%.
- The practice held a register of patients experiencing poor mental health and offered regular reviews and same day contact.
- The practice referred patients to the Improving Access to Psychological Therapies service (IAPT) and encouraged patients to self-refer.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record, in the preceding 12 months, was 98%, which was above the CCG average of 92% and national average of 89%.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We looked at the National GP Patient Survey results published in July 2016. The results showed the practice was performing mostly below local and national averages. There were 257 survey forms distributed and 104 were returned. This represented a 40% response rate and approximately 0.5% of the practice's patient list.

- 33% of patients found it easy to get through to this practice by phone compared to the local average of 63% and national average of 73%.
- 80% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 82% and national average of 85%.
- 69% of patients described the overall experience of this GP practice as good compared to the local average of 82% and national average of 85%.
- 56% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 74% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 12 comment cards. All comment cards were positive about the standard of care received. We spoke with 11 patients who told us the GPs and nurses acted in

a professional and courteous manner and described the services provided by all staff as very caring, accommodating and friendly. Patients also told us that they found it difficult to get through to the surgery on the telephone and obtain an appointment which was convenient to them. We received feedback from 11 members of the Patient Participation Group (PPG) and seven members told us that they found it difficult to get an appointment that was convenient to them and experienced difficulties contacting the practice on the telephone.

The practice had gathered patient feedback using the NHS Friends and Family Test (FFT). The FFT asks people if they would recommend the services they have used and offers a range of responses. The practice had received 55 responses to the FFT between February and August 2016. The results showed 35 people (63%) were either extremely likely or likely to recommend the service and 19 people (35%) were either extremely unlikely or unlikely to recommend the service.

The practice had made changes to their appointment system and offered more routine appointments. The practice told us that they were in the process of identifying a new telephone supplier in order to improve access to the practice by telephone.

Areas for improvement

Action the service MUST take to improve

- Ensure the systems and processes are in place for safe prescribing of medicines, including high risk medicines, and the timely management of clinical records received into the practice, including secondary care clinical notifications and pathology results.
- Ensure systems are implemented to enable staff learning needs to be identified through a system of staff appraisals.
- Ensure completion and effective management of the actions identified in the Legionella risk assessment.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.

- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure processes are improved to enable effective communication.

Action the service SHOULD take to improve

- Complete a periodic review of significant events to identify trends.
- Include information on the Parliamentary Health Service Ombudsman when formally responding to complaints.
- Continue to review and monitor the National GP Patient Survey results to ensure improvement.

Summary of findings

- Review and make improvements disabled patient toilet facilities provided in line with the requirements of the Equality Act 2010.
- Ensure an appropriate system is in place for the safe monitoring of blank prescriptions.
- Continue to monitor infection prevention and control through audits across all premises.
- Review the business continuity plan and ensure it meets current circumstances.

Peartree Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a regional GP specialist advisor, a practice manager specialist advisor and an Expert by Experience.

Background to Peartree Surgery

Peartree Surgery provides primary medical services, including minor surgery, to approximately 22,000 patients in Welwyn Garden City, Hertfordshire. Services are provided on a General Medical Services (GMS) contract (a nationally agreed contract). The practice operates across three premises. Peartree Surgery is the main surgery and was purpose built in 1993. All patient consultations are held on the ground floor. There is an on-site pharmacy which has been operating since 2012.

Moorswalk Surgery is a branch surgery located approximately two miles away from the main surgery and Hollybush Lane Surgery is a branch surgery located approximately one mile away from the main surgery. Hollybush Lane surgery currently does not offer patient consultations due to the retirement of four GP partners over the last two years and the current absence of two of the GP partners.

The practice serves a slightly higher than average population of those aged between 0 to 9 years and a slightly lower than average population of those aged between 65 to 79 years. The population is 88% White British (2011 Census data). The area served is less deprived compared to England as a whole.

The practice team consists of seven GP Partners and two salaried GPs; four of which are male and five are female. There are three long term locums. There are two nurse practitioners, who are both qualified to prescribe certain medicines, six practice nurses and one health care assistant. The practice told us 74 clinical sessions are provided each week.

The non-clinical team is made up of a practice manager, deputy practice manager and 29 members of the administration and reception team.

Peartree Surgery is a training practice and has been approved to train doctors who are undertaking further training (from four months up to one year depending on where they are in their educational process) to become general practitioners.

Peartree Surgery and Moorswalk Surgery are open to patients between 8am and 6:30pm Mondays to Fridays. Appointments with a GP are available from approximately 8.30am to 12pm and from 3pm to 6.30pm daily. Emergency appointments are available daily. A telephone consultation service is also available for those who need urgent advice. The practice offers extended opening hours at the main practice between 6.30pm and 8pm three evenings each week, and on Saturdays from 8am to 11am on a fortnightly basis.

Home visits are available to those patients who are unable to attend the surgery and the Out of Hours service is provided by Hertfordshire Urgent Care and can be accessed via the NHS 111 service. Information about this is available in the practice, on the practice website and on the practice telephone line.

Detailed findings

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

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We contacted NHS East and North Hertfordshire Clinical Commissioning Group (CCG), Healthwatch and the NHS England area team to consider any information they held about the practice. We carried out an announced inspection on 19 October 2016. During our inspection we inspected the main practice and the operational branch surgery and we:

- Spoke with four GPs, two practice nurses, the health care assistant, the practice manager, the deputy practice manager, two members of the administration team and two members of the reception team.
- Spoke with 11 patients and observed how staff interacted with patients.

- Reviewed 12 CQC comment cards where patients and members of the public shared their views and experiences of the service.
- Spoke with two members of the Patient Participation Group (PPG) and received feedback from nine members of the PPG. (This is a group of volunteer patients who work with practice staff on making improvements to the services provided for the benefit of patients and the practice).

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

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

- There was a lack of reporting of significant events and the practice had only recorded six significant events since April 2015. The practice did not analyse significant events over time to identify trends.
- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Senior staff understood their roles in discussing, analysing and learning from individual incidents and events. We were told that the event would be discussed with the GP partners as soon as possible and acted on and also discussed at clinical meetings, which took place monthly. We saw evidence to confirm this.

We reviewed safety records, incident reports, MHRA (Medicines and Healthcare products Regulatory Agency) alerts and patient safety alerts. We saw evidence to confirm action was taken to improve safety in the practice. For example, the practice had received a safety alert about the packaging of a certain type of syringe. The practice carried out a search of their stock and then took the appropriate action.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, however during our inspection we found some of these systems and processes to be insufficient:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a GP lead for

safeguarding adults and a GP lead for safeguarding children. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and had received training relevant to their role. All nurses and GPs were trained to an appropriate level to manage safeguarding children (level 3) and adults.

- The practice displayed notices in the waiting area and treatment and consulting rooms which advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and a risk assessment was in place for all staff including circumstances in which staff acted as a chaperone without having a disclosure and barring service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The senior practice nurse was the infection control lead. There was an infection control protocol in place and staff had received up to date training. The practice had not previously undertaken an infection control audit. At the time of our inspection, the practice was in the process of completing an infection control audit. The audit had been completed on some of the treatment rooms and we saw evidence that action had been taken to make the necessary improvements identified as a result. The practice had a timetable in place to complete the infection control audit in all patient areas across the three premises.
- All single use clinical instruments were stored appropriately and were within their expiry dates. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available and clinical waste was stored appropriately and collected from the practice by an external contractor on a weekly basis.
- During our inspection we found that the disabled toilet did not have a call bell to alert staff in the event of an emergency. Shortly after the inspection the practice told us that they were making arrangements for an emergency call bell to be installed in the disabled toilet.

Are services safe?

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- During our inspection we found the arrangements in place for prescribing medicines including the processes for handling repeat prescriptions, which included high risk medicines, did not keep patients safe. We checked the prescribing processes in place for patients receiving methotrexate (a medicine used to treat cancer, rheumatoid arthritis or certain other conditions). At the time of inspection we identified 106 patients on methotrexate. Patients on methotrexate require a blood test on a three monthly basis to check their full blood count (FBC). We looked at five patient records and found three of these patients had been prescribed methotrexate without an up to date record of their FBC. The practice did not have a written policy in place for repeat prescribing or high risk medicine monitoring. Shortly after the inspection the practice submitted an action plan in response to the risks identified. Following the inspection, the practice told us that specific blood test results were not automatically populating on their clinical system despite having been received by the practice. The practice told us that they were now entering the results manually after identifying the fault with the clinical system.
- However, during our inspection we found that the systems and processes in place for managing clinical records were insufficient. We were told all documents submitted to the practice by the Out of Hours service were scanned into the practice's electronic mail inbox and allocated to the GPs. At the time of inspection there were approximately 400 documents in the inbox, not all of these had been reviewed and passed on for action. We also found 17 were allocated to a GP who left on 30 September 2016 and we found one had been allocated to a GP who had been on maternity leave since May 2016. Following the inspection the practice told us that this document had been allocated to this GP for their information only. The practice told us that they had now implemented a policy to ensure that departing GPs and locum doctors have their pathology and scanned documents safely diverted.
- We checked the management of pathology results and we found that there were 124 results prior to 14 October 2016 which had not been acted on. These pathology results dated back to 9 September 2016. The practice took immediate steps to action the Out of Hours records and pathology results and told us that a new system would be implemented.
- Blank prescription forms and pads were securely stored. However there was no system in place to monitor their use.
- Patient Group Directions had been adopted by the practice to allow the nurses to administer medicines in line with legislation.
- We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety in some areas. However, during our inspection we found examples where risks to patients were not being managed effectively.

- There was a health and safety policy available along with a poster in the staff area which included the names of the health and safety lead at the practice. The practice had up to date fire risk assessments. Fire equipment was checked on a regular basis and fire alarms were tested weekly. However, the practice had not completed a fire drill at the practice and there was no record of any previous fire drills. Shortly after the inspection the practice provided us with evidence of a fire drill which had been completed at the main practice and operational branch surgery. The practice told us that they would be completing a fire drill at each premises on a quarterly basis. All electrical equipment was checked in March 2015 to ensure the equipment was safe to use and clinical equipment was checked in July 2016 to ensure it was working properly.
- An external contractor had completed a Legionella assessment in March 2015. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). This assessment had identified 17

Are services safe?

requirements and checks. There were 12 areas of high priority (action should be taken immediately and should be completed within three months of the date of this risk assessment), four areas of medium priority (appropriate action should be undertaken within six months of the date of this risk assessment) and one area of low priority (appropriate action should be undertaken within 12 months of the date of this risk assessment). The practice had not acted on any of these requirements. Following our inspection the practice told us that a new Legionella risk assessment had been scheduled to be completed on 26 October 2016.

- The practice had a risk assessment in place for the control of substances hazardous to health (COSHH).
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There were individual team rotas in place to ensure that enough staff members were on duty. The practice had a system in place for the management of planned staff holidays and staff members would be flexible and cover additional duties as and when required during other absences. The practice used locums and would complete the necessary recruitment checks on those individuals.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a defibrillator available and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the emergency medicines we checked were in date.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. However, this plan had been reviewed in April 2016 however the emergency contact list for staff members was not up to date.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met people's needs.
- The practice monitored that these guidelines were followed through risk assessments and random sample checks of patient records.
- The practice engaged with the local East and North Hertfordshire Clinical Commissioning Group (CCG) and accessed CCG guidelines and also analysed information in relation to their practice population. For example, the practice would receive information from the CCG on accident and emergency attendance, emergency admissions to hospital and prescribing rates.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice achieved 98% of the total number of points available, with 10% exception reporting which was comparable with the local average of 8% and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2014/2015 showed;

- The percentage of patients aged 45 years or over who have a recorded blood pressure in the preceding five years was in line with the CCG and national average. The practice had achieved 90% of the total number of points available, compared to the CCG average of 90% and national average of 91%. Exception reporting for this indicator was 3% which was comparable with the CCG and national average of 1%.

- 88% of patients diagnosed with asthma, on the register, had received an asthma review in the last 12 months which was above the CCG average of 74% and national average of 75%. Exception reporting for this indicator was 29% which was above the CCG average of 6% and national average of 8%. We checked the exception reporting system and saw that the practice had an effective recall system in place and a systematic approach for recording exceptions. We checked unverified data for 2015/2016 and found exception reporting for this indicator had reduced to 5%.
- 72% of patients diagnosed with dementia had their care reviewed in a face to face meeting in 2014/2015, which was below the CCG average of 86% and national average of 84%. Exception reporting for this indicator was 6% which was comparable with the CCG average of 8% and national average of 7%. The practice told us that two GPs had been given designated time to carry out these reviews. We checked three patient records and found all three patients had thorough care plans in place.
- The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification within the preceding 12 months was 86%, which was comparable with the CCG average of 89% and national average of 88%. Exception reporting for this indicator was 7% which was the same as the CCG and national average.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record, in the preceding 12 months, was 98%, which was above the CCG average of 92% and national average of 89%. Exception reporting for this indicator was 24% which was above the CCG and national average of 13%. We checked three patient records and found all three patients had appropriate care plans in place which were being reviewed on a regular basis. We looked at three records for patients who had been exception reported and found two of these patients were receiving a regular review by the local community mental health team. However, we found one patient who was not being seen by the local community mental health team and they were last seen by the practice in September 2014.

Clinical audits demonstrated quality improvement.

Are services effective?

(for example, treatment is effective)

- There had been six clinical audits undertaken in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings from audits were used by the practice to improve services. For example, one of these audits looked at antibiotic prescribing for tonsillitis. This audit examined the rates for antibiotic choice prescribing and adherence to NICE guidelines. This audit was repeated and the results showed a slight improvement in prescribing the appropriate type of antibiotic. One of the action points from this audit was to develop a prescribing alert on the clinical system when treating a patient for tonsillitis.

Effective staffing

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, equality and diversity, infection control, information governance, basic life support, health and safety and fire safety.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff taking blood samples, administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, attendance to educational sessions, conferences and discussions through a locally run nurse forum.
- The learning needs of staff were identified through a system of informal discussions and staff meetings. During our inspection we found a significant number of non-clinical staff members had not received an appraisal within the last 12 months. One of the practice nurses had not received an appraisal since May 2015. There were 31 members of the non-clinical team, two of which had received an appraisal in 2016. Five of these staff members had received an appraisal in 2014 and eight staff members had received an appraisal in 2013.

The practice had recently implemented a new system to complete staff appraisals and told us that a timetable was in place to complete all staff appraisals by 14 December 2016.

- Staff had access to essential training to cover the scope of their work. Staff training was provided through on line learning, internal and external training sessions and CCG led training days, which took place on a quarterly basis.
- Nursing staff had lead roles in chronic disease management and regularly held clinics to review patients. The nurse practitioners had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the GPs for this extended role. At the time of our inspection we found this supervision was informal and ad-hoc.

Coordinating patient care and information sharing

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets was also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. The practice made referrals to secondary care through the E-referral System (this 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 in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system and attached to patient records.
- Staff worked together with other health and social care services to understand and meet the range and complexity of patient needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they

Are services effective?

(for example, treatment is effective)

were referred to, or after they were discharged from hospital. We were told that multi-disciplinary team meetings took place on a monthly basis for vulnerable patients and for patients requiring palliative care.

- Named GPs carried out a weekly visit to three local care homes. We spoke to a manager at each care home and they told us the practice provided a good service. They described the practice as accessible and responsive to needs of their residents and were positive about all aspects of the services provided by the practice.
- The practice provided services to three local supported living premises for adults with learning disabilities. We spoke with a staff member at two of these premises and they told us that they were satisfied with the care and treatment provided, and the practice staff were very good at supporting both the residents and the staff members.

Consent to care and treatment

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

- The practice had a consent policy in place and staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

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

- These included patients considered to be in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, drug and alcohol cessation, homeless people and patients experiencing poor mental health. Patients were then signposted to the relevant services.

- The practice worked closely with a nearby hostel and provided support to service users and staff members.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had completed 14 health checks out of 101 patients since April 2016, which was 14% of patients on the learning disability. The practice told us that the GP lead for learning disabilities had been on leave and was due to return in November 2016. The practice told us that a meeting with the community learning disability liaison nurses had been arranged and time had been allocated for this GP to complete the learning disability health checks.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 83% and the national average of 82%. The exception reporting was 4% which was comparable with the local average of 5% and national average of 6%. The practice encouraged uptake of the screening programme by ensuring a female clinician was available and by sending letters to patients who had not responded to the initial invitation.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice told us that their uptake for breast screening was 63% and 77% for bowel screening.

Patients had access to appropriate health assessments and checks. The practice offered NHS health checks for people aged 40–74 years and had completed 182 in the last 12 months. New patients had their needs assessed upon registering and were offered a health check.

The practice provided health checks for patients aged over 75 years and had completed 172 in the last 12 months. The practice had completed 1,025 health checks since September 2014, which was 63% of this population group. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

We received 12 CQC patient comment cards. Patients said they felt the practice offered a good service and said staff were helpful, caring, friendly and treated them with dignity and respect.

We received feedback from 11 patients and 11 members of the patient participation group (PPG). Patients told us that they were satisfied with the care provided by the GPs and nurses and said their dignity and privacy was respected. Patients told us that staff responded compassionately when they needed help and provided support when required. However, eight patients told us that the quality of the customer service provided by the reception staff could be improved.

Results from the National GP Patient Survey published in July 2016 showed the practice was mostly comparable with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 80% said the GP gave them enough time compared to the CCG average of 85% and the national average 87%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.

- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 88% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 62% said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

The practice told us that they were aware of the below average scores and had scheduled customer service training for staff members which was scheduled to take place in January 2017.

Care planning and involvement in decisions about care and treatment

Results from the National GP Patient Survey published in July 2016 showed the practice was performing slightly below local and national averages for patient questions about their involvement in planning and making decisions about their care and treatment. For example:

- 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 74% said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 78% and the national average of 82%.
- 80% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

The patients we spoke with or who left comments for us told us they felt involved in decision making about the care and treatment they received. They said their questions were answered by clinical staff and any concerns they had were discussed. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

The practice provided translation services for patients who were hard of hearing or did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Are services caring?

- Notices in the patient waiting rooms 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 held a register of carers with 467 carers identified which was approximately 2% of the practice list. A member of the reception team was the practice's carers lead (a Carers' champion) and information about local support groups and services was made available to patients.
- Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and East and North Hertfordshire Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, a Phlebotomist from the local hospital visited the practice and branch surgery two times a week to take blood samples from patients for required testing.

- The practice had signed up to an enhanced service to manage unplanned hospital admissions for vulnerable and at risk patients. These patients had a personalised care plan and all of these patients had a named GP and regular reviews.
- The practice maintained a register of vulnerable patients. This patient list enabled the practice to identify patients with additional needs and raised awareness for staff to ensure the practice communicated effectively and provide flexible services to these patients.
- The practice was proactive in offering on line services such as appointment booking, an appointment reminder text messaging service and repeat prescriptions, as well as a full range of health promotion and screening that reflects the needs of this age group.
- The practice provided an electronic prescribing service (EPS) which enabled GPs to send prescriptions electronically to a pharmacy of patients' choice.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice offered a range of family planning services. Baby vaccination clinics and ante-natal clinics were held at the practice on a regular basis. A community midwife held a clinic at the practice on a weekly basis.
- The practice referred patients to the Improving Access to Psychological Therapies service (IAPT) and encouraged patients to self-refer.
- A NHS counsellor provided sessions at the practice on a regular basis for registered patients and for patients from neighbouring practices.

- There were longer appointments available for patients with a learning disability. Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- The practice had also launched a new website in October 2016 which included a GP webpage portal which enabled patients to contact a GP and receive a response via e-mail within 72 hours.
- Staff members were aware of the need to recognise equality and diversity and acted accordingly. The practice had a system in place to identify patients with a known disability.

Access to the service

The main practice and branch surgery were open to patients between 8am and 6.30pm Mondays to Fridays. Appointments with a GP were available from 8.30am to 12pm and from 3pm to 6.30pm daily. The practice offered extended surgery hours between 6.30pm and 8pm three evenings each week, and on Saturdays from 8am to 11am on a fortnightly basis. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

Results from the National GP Patient Survey published in July 2016 showed that patients' satisfaction with how they could access care and treatment was below local and national averages.

- 56% of patients were satisfied with the practice's opening hours compared to the CCG average of 69% and national average of 76%.
- 33% of patients said they could get through easily to the surgery by phone compared to the CCG average 63% and national average of 73%.

The practice told us that they were in the process of obtaining quotes for a new telephone service provider. The majority of patients we spoke with on the day of inspection told us that they found it very difficult to get through to the practice on the telephone. After the inspection the practice told us that an upgraded telephone system had been scheduled to be installed in January 2017.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

(for example, to feedback?)

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.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- Information to help patients understand the complaints system was available on the practice website and in the patients' waiting areas.
- Verbal complaints were being recorded and analysed.

We looked at four complaints received in the last 12 months and found all of these had been recorded and handled appropriately. All complaints had been dealt with in a timely way and there was openness and transparency

when dealing with complaints. However, the practice did not provide patients with information on the role of the Parliamentary and Health Service Ombudsman (PHSO) when responding to patient complaints as standard.

The practice had a comments and complaints leaflet which included information on the PHSO (the PHSO make final decisions on complaints that have not been resolved by the NHS in England). Shortly after the inspection the practice sent us new templates for responding to patient complaints which included information about the PHSO.

The practice shared their complaints data with NHS England. Apologies were offered to patients, lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, the practice organised customer service training for practice staff following a patient complaint.

Are services well-led?

Inadequate 

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

Our findings

We found major flaws in the leadership and governance of this practice.

Vision and strategy

The practice had a vision to improve the health, wellbeing and lives of the patients they care for.

- The practice had a mission statement which was displayed on the staff noticeboard and staff knew and understood the values.
- The practice had a business development plan in place to improve access, capacity and the patient experience. However, this plan was basic and lacked details on strategic and succession planning.

Governance arrangements

We found a lack of governance processes at the service and the leadership team had not ensured that systems and processes were effective in all areas. For example:

- During our inspection we found systemic weaknesses in governance systems such as ineffective monitoring of patients receiving high risk medicines. We found inadequate systems in place for the safe management of clinical records from secondary care services including hospital pathology results and information from the Out of Hours service.
- The practice had some systems in place to understand the performance however we found that there were no overarching arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice had failed to identify risks in relation to the management of blank prescriptions, the action required following the Legionella risk assessment, and the lack of infection control auditing.
- The practice's process for identifying and recording significant events was not effective. The practice had recorded six significant events since April 2015 and did not analyse significant events over time to identify trends.
- The practice had failed to identify risks to patients using the disabled toilet and the business continuity plan was not up to date

- Whilst the practice had practice specific policies, they were lacking policies for high risk medicines and repeat prescribing.

Leadership and culture

Clinical staff had lead roles in a number of areas such as learning disabilities, safeguarding and dementia. A list of clinical staff with lead roles was displayed on a notice board in each clinical room. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

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

During our inspection we identified an overarching lack of leadership to understand all aspects of the practice. The practice told us that they had commissioned an external company to review the practice's structure, systems and processes.

Staff told us the practice held regular team meetings and we saw evidence that regular staff meetings were taking place for all staff groups including multidisciplinary team meetings.

- The GP partners held business planning away days on a quarterly basis.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the practice manager and also the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to

Are services well-led?

Inadequate 

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

identify opportunities to improve the services delivered by the practice. However, there was no formal programme in place for the regular appraisal of all staff members at the practice.

- Senior staff regularly attended meetings with peers within their locality. The practice was a member of a local GP Federation and one of the partners was a director. One of the GP partners was a member of the Local Medical Committee and one of the GP partners had a special interest (GPwSI) in dermatology.
- The clinical team has experienced significant pressures over the past 12 months since November 2015 with several absent GPs, this has led to dependency on the use of locum GPs.

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

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

- The practice had gathered feedback from patients through the Friends and Family Test, through comments and complaints received and through the Patient Participation Group (PPG). The PPG was an established group and held regular meetings with practice staff. The PPG had worked with practice staff and had made improvements to the information made available to patients on a number of areas including hospital transport services, the complaints procedure and the staff structure. However, at the time of inspection the practice was not following their complaints procedure when responding to complaints.
- The practice had gathered feedback from staff through meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: We found the provider had not responded to the Legionella risk assessment completed in March 2015. We found the majority of non-clinical staff members had not received an appraisal on a regular basis and one of the nurse's appraisal was also overdue.

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Patients receiving medicines that require monitoring, including high risk medicines were at risk of harm because these patients were not being monitored appropriately and some of these patients had not received the required checks. We found the management of clinical records from secondary care services was not adequate. Results from the hospital and records from the Out of Hours service were not always acted on in a timely way.