Stockwell Lodge Medical Centre

Quality Report

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Date of inspection visit: 18 May 2017
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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?	**Inadequate**
Are services responsive to people's needs?	**Inadequate**
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 Stockwell Lodge Medical Centre on 18 May 2017. 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 were not in place to keep them safe. For example, the practice had did not have systems in place for the monitoring of medicines and infection prevention control.
- We found the condition of the practice to be poor and the practice had not maintained appropriate levels of cleanliness and identified concerns had not been addressed in relation to infection control.
- There was a system in place for reporting and recording significant events. However we did not see evidence that information and learning was disseminated to all staff.
- Staff were aware of current evidence based clinical guidance however we saw little evidence of it being followed.
- The practice staff were aware of their responsibilities regarding child & adult safeguarding with good signposting throughout the practice. Whilst the majority of staff had undergone safeguarding training we saw that there were gaps in safeguarding training in particular one member of clinical staff had not received formal training.
- Results from the Quality Outcome Framework (QoF) showed patient outcomes were comparable to the local and national averages. Although some audits had been carried out, we saw no evidence that audits were driving improvements to patient outcomes.
- National GP patient survey data published July 2016 was considerably lower than local and national averages. Information received from the East and North Herts Clinical Commissioning Group (CCG) identified that the practice was one of the lowest scoring practices nationally.

Summary of findings

- The majority of patients we spoke to said they were treated with compassion, dignity and respect. However patients consistently told us that they experienced difficulties in getting an appointment and they felt the condition of the premises was poor.
- The practice had no clear leadership structure and designated lead roles in key areas were ineffective. There was a lack of adequate formal governance arrangements in place, for example staff were unaware of where to access policies and procedures.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients, for example the safe prescribing and monitoring of medicines, appropriate management and monitoring of infection prevention control and maintenance of equipment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care, ensure systems or processes assess, monitor and improve the quality and safety of the serves provided.

The areas where the provider should make improvement are:

- Ensure monitoring and improvement to national GP patient survey results for example, patient experience and access to appointments.
- Ensure that all staff undertake training on the appointment system and have a comprehensive understanding of the appointments system, in particular with relation to access to emergency appointments.
- Ensure the baby changing unit is safe to use and is of a material that aids cleaning and hygiene.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- 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 medicines were inadequate.
- Blank prescription forms and pads were securely stored and there was a system in place to monitor their use.
- Staff understood their responsibilities in relation to significant events and were aware of the process to report incidents and near misses. Although the practice carried out investigations when there were unintended or unexpected safety incidents, lessons learned were not communicated and trends were not identified to ensure safety was improved. Patients did however receive reasonable support, a verbal and written apology.
- An infection control audit had been carried out in January 2017 which documented a number of concerns and infection control issues. Although we saw some of the issues had been addressed, we saw no evidence of an action plan with timescales for completion to ensure all issues identified would be resolved.
- There were no risk assessments in place to monitor health and safety of the premises such as legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There was no evidence of a health and safety risk assessment. However, immediately following the inspection we were sent a copy of a health and safety risk assessment. Upon reviewing the submitted risk assessment it was noted to be incomplete. The risk assessment was not dated and did not have an action plan.
- Staff demonstrated that they understood their responsibilities regarding adult and child safeguarding however, one member of clinical staff had not received formal training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- The practice had a comprehensive business continuity plan which contained contact details for contractors and staff.

Summary of findings

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services as there are areas where improvements should be made.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable with or above average compared to local and national averages.
- The percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c was 64 mmol/mol or less in the preceding 12 months was 64%, where the CCG average was 76% and national average was 78%.
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness in the preceding 12 months was 95% which was comparable to the CCG average of 91% and national average of 90%.
- Knowledge of and reference to national clinical guidelines were inconsistent. The practice did not have a formal system in place to ensure that all clinical staff were kept up to date with clinical guidelines.
- There was no evidence that audit was driving improvement in patient outcomes.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.
- There was no evidence that the practice was comparing its performance to others; either locally or nationally.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services and improvements must be made.

- Data from the most recent national GP patient survey published July 2016 showed patients rated the practice lower than others for many aspects of care. For example:

- 59% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 46% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.

Summary of findings

- 74% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and the national average of 92%
- 54% of patients 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%.
- 48% of patients said they found the receptionists at the practice helpful compared with the CCG average of 83% and the national average of 87%.
- The patient participation group had carried out their own survey annually and the most recent results collected between March and May 2016 showed positive improvements.
- The majority of patients we spoke to on the day of the inspection and CQC patient comment cards received were positive about the care and treatment they received
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 402 patients as carers (approximately, 3% of the practice list). Information on how to access support was available on the carers display in the waiting area.
- Interpretation services were available for patients who did not have English as a first language.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Data from the National GP Patient Survey results published in July 2016 showed patients rated the practice as below average for several areas relating to access to services, for example,
- 45% of patients were satisfied with the practice's opening hours compared with the local clinical commissioning group (CCG) average of 69% and the national average of 76%.
- 14% of patients said they could get through easily to the practice by phone compared to the CCG average of 62% and national average of 74%.
- 25% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 23% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 55% and the national average of 56%.
- There was a triage system in place for patients who were vulnerable, small children or elderly. However, we saw that not all staff understood the system and gave out the wrong

Summary of findings

information to patients regarding appointments. We saw that patients were told that there were no appointments available despite being informed by the practice that the GPs would see all patients requiring urgent care.
- Patients we spoke to told us that they experienced difficulty in accessing services at the practice including appointments. Comment cards received from patients also reflected these views.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients could get information about how to complain in a format they could understand. Although complaints were shared with the patient participation group there was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate

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.
- The provider was aware of their requirements of the duty of candour although one GP we spoke to was unsure of the responsibilities.
- The practice had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it.
- There was a documented leadership structure and most staff felt supported by management but however staff told us that at times they were not sure who to approach with queries and concerns.
- The practice had a number of policies and procedures to govern activity, however some staff we spoke to were not aware of how to access them
- All staff had received induction and had received regular performance reviews.
- The practice had proactively sought feedback from staff or patients and had an active patient participation group who worked well with the practice as a 'Critical friend'.
- Whilst the practice had undertaken a number of audits these were not focused on areas of underperformance and therefore we were unable to evidence continuous clinical improvement.

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

Inadequate

The practice is rated as inadequate for providing safe, caring, responsive and well-led services and requires improvement for providing effective services. The issues identified as inadequate and requiring improvement affected all patients including this population group. However there was some evidence of good practice.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice participated in the Home First and Rapid Response services provided locally.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. They involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and we saw evidence that care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Inadequate

The practice is rated as inadequate for providing safe, caring, responsive and well-led services and requires improvement for providing effective services. The issues identified as inadequate and requiring improvement affected all patients including this population group. However there was some evidence of good practice.

- Nursing staff and practice pharmacists had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- The percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c was 64 mmol/mol or less in the preceding 12 months was 64%, where the CCG average was 76% and national average was 78%.
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness in the preceding 12 months was 95% which was comparable to the CCG average of 91% and national average of 90%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for 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 the Home First team to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for providing safe, caring, responsive and well-led services and requires improvement for providing effective services. The issues identified as inadequate and requiring improvement affected all patients including this population group. However there was some evidence of good practice.

- We saw children were not always given emergency appointments.
- The practice baby change unit was not for purpose.
- There were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- 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 'Kooth' an online counselling and emotional wellbeing service specifically for children and young people.

Summary of findings

- The practice's uptake for the cervical screening programme was 87%, which was above the CCG average of 83% and the national average of 81%.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for providing safe, caring, responsive and well-led services and requires improvement for providing effective services. The issues identified as inadequate and requiring improvement affected all patients including this population group. However there was some evidence of good practice.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours offering early morning and evening appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. For example,
- 72% of females, aged 50-70 years, were screened for breast cancer in last 36 months compared to the CCG average of 72% and the national average of 73%.
- 59% of patients, aged 60-69 years, were screened for bowel cancer in last 30 months compared to the CCG average of 60% and the national average of 58%.
- The practice carried out routine NHS health checks for patients aged 40-74 years these we carried out by the practice nurse and health care assistant.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for providing safe, caring, responsive and well-led services and requires improvement for providing effective services. The issues identified as inadequate and requiring improvement affected all patients including this population group. However there was some evidence of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had completed 17 health checks out of 45 patients since July 2016, 15 had declined and 12 had not responded to the invitation. The practice demonstrated they had a system in place to ensure that those patients who had not attended were encouraged to do so and were offered options to enable this.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals including the Rapid Response team in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- GPs attended local safeguarding meetings.
- The practice had identified 402 patients as carers (approximately, 3% of the practice list).
- The practice offered annual health checks for patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for providing safe, caring, responsive and well-led services and requires improvement for providing effective services. The issues identified as inadequate and requiring improvement affected all patients including this population group. However there was some evidence of good practice.

- The practice carried out advance care planning for patients living with dementia.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 81% where the CCG average was 86% and the national average was 84%.
- The percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 90% where the East and North Herts Clinical Commissioning Group (CCG) average was

92% and the national average was 89%. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.

- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health and dementia.
- The practice assisted patients experiencing poor mental health to access various support groups and voluntary organisations including MIND and SANE.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published in July 2016. The results showed the practice was performing significantly below local and national averages. Of the 260 survey forms distributed 126 were returned. This represented a response rate of approximately 48% and 1% of the total practice patient list.

- 30% of patients described the overall experience of this GP practice as good compared with the CCG average of 82% and the national average of 85%.
- 25% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 19% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local CCG average of 75% and the national average of 80%.

Of the 18 Care Quality Commission patient comment cards we received, 12 contained positive comments about the service received and availability of specific GPs. Six responses commented on poor service, lack of access to appointments and the poor condition of the premises.

We spoke with five patients during the inspection and of the five patients we spoke with four told us it was very difficult to get through on the telephone and to get an appointment. Two said the quality of care varied according to which GP they saw, but all five said they were given enough time during consultations.

There were no recent friends and family test results available since 2014 the practice informed us and we saw evidence that whilst they had encouraged patients to complete the forms none had been received.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients, for example the safe prescribing and monitoring of medicines, appropriate management and monitoring of infection prevention control and maintenance of equipment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care, ensure systems or processes assess, monitor and improve the quality and safety of the serves provided.

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Ensure monitoring and improvement to national GP patient survey results for example, patient experience and access to appointments.
- Ensure that all staff undertake training on the appointment system and have a comprehensive understanding of the appointments system, in particular with relation to access to emergency appointments.
- Ensure the baby changing unit is safe to use and is of a material that aids cleaning and hygiene.

Stockwell Lodge Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC Inspector**.** The team included a GP specialist advisor, a second CQC inspector and a practice manager specialist advisor.

Background to Stockwell Lodge Medical Centre

Stockwell Lodge Medical Centre provides a range of primary care services to approximately 13,400 patients who live in Cheshunt, Waltham Cross, Hertfordshire.

The practice population is of mixed ethnic background with a slightly higher than average male population aged between 20 to 34 years and 50 to 64 years of age and female patients this is higher for those aged between 45 and 64 years of age. National data indicates the area served is of low deprivation in comparison to England as a whole and has low levels of unemployment.

The service operates from a two storey building with a preventative care unit adjacent. The reception area is equipped with electronic patient arrival registration screens and a hearing loop for patients with hearing impairment. There is car parking available for patients with designated disabled bays.

The clinical team consists of four GP partners (three male and one female), a female salaried GP, a locum practice nurse, two health care assistants (one male, one female) and two pharmacists. The team is supported by a practice manager and a team of reception and administration staff.

The practice holds a General Medical Services (GMS) contract for providing services, which is a nationally agreed contract between general practices and NHS England for delivering general medical services to local communities. The practice is registered with the CQC to undertake a number of regulated activities; diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease, disorder or injury.

The practice is open between 8am and 6.30pm Monday to Friday with extended hours appointments available on Monday, Tuesday and Wednesday mornings from 7.30am and Monday and Tuesday evenings until 8pm and 7.30pm respectively.

When the practice is closed the out of hours service is provided by Herts Urgent Care Services for patients requiring the services of a GP. Information about this is available in the practice and on the practice leaflet, website and telephone line.

Why we carried out this inspection

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 or example the clinical commissioning group and NHS England to share what they knew.

We carried out an announced visit on 18 May 2017. During our inspection we:

- Spoke with a range of staff including GPs, nursing staff, the practice manager and support staff. We also spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 living 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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

Whilst there was a system in place for reporting and recording significant events, we found that information and learning from incidents was not always shared with staff.

- 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 recording 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).
- Significant events were recorded and we found evidence where these were investigated and discussed at practice meetings. For example, we saw evidence of an incident where the practice bypass number was unavailable due to a fault. The incident was discussed in a practice meeting to ensure that all staff were aware of the actions to take if they were presented with this situation in the future, including referring to the business continuity plan for guidance. However there was no evidence to show a systematic approach to ensure information was cascaded to all staff, to improve learning and prevent reoccurrence and staff we spoke to confirmed that they did not have the knowledge.
- From the sample of three documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received support, a written apology and were told about any actions taken to improve processes to prevent the same thing happening again.
- We saw no evidence of analysis of trends regarding significant events or complaints.

We reviewed safety records, incident reports, patient safety alerts including those received from the MHRA (Medicines and Healthcare Regulatory Agency) and found a system in place to ensure these were being actioned All alerts were managed by the pharmacists, searches were carried out by the pharmacists and then were reviewed by the GPs, actions taken where appropriate. For example, where an alert recommended a reduction in the dosage of a medication we saw evidence that patients affected were contacted with information regarding the change. A summary of patient alerts was compiled and distributed to all clinicians and we saw evidence in the form of a tracking sheet and minutes of meetings to confirm that alerts were being discussed.

Overview of safety systems and processes

The practice had limited systems and processes in place to keep patients safe and during our inspection we found that many of the processes to be insufficient to ensure patient safety.

- Arrangements for safeguarding children and vulnerable adults reflected relevant legislation and local requirements. The practice policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the sample of documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff had undertaken safeguarding training including the GPs with lead roles who were trained to the appropriate level (level three), however we found that one of the health care assistant had not undertaken any safeguarding training. However staff we spoke to had a good understanding of their responsibilities in relation to safeguarding, including the signs to look for and how to report any concerns.
- There was good signposting throughout the practice and in all clinical areas, reception and the waiting area giving details of the safeguarding leads and relevant contact telephone numbers.
- The practice staff advised patients that chaperones were available if required however we found no notices in the practice to advise patients that chaperones were available. By the end of the day the practice ensured that posters advising patients of the role of the chaperone were placed throughout the practice.
- Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (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).

- During our inspection we found the baby change unit did not have a weight restriction notice or was not fitted with safety straps, the unit was made of wood and therefore was not of a suitable material that could be easily cleaned.

The practice had not maintained appropriate standards of cleanliness and hygiene.

- During our inspection we found the building was not visibly clean. We saw an audit had been undertaken by an external cleaning contractor on 21 April 2017 which had been signed off by the practice and stated all areas were completed to the satisfactory standard. There was no deep cleaning schedule in place for the carpets although we were told this had been completed in 2016. We saw that the staff area had not been vacuumed and the bins had not been emptied. We were told that blood samples and swabs were being taken by a GP in a clinical room with a stained carpet.
- Curtains in consulting rooms had been changed and were dated. Carpets throughout the practice were dirty and desks were dusty and some were cluttered. There was an unpleasant odour throughout the ground floor of the building. There was a mat in the entrance corridor which had several large tears which could have presented a trip hazard; the practice had placed a wet floor notice to highlight the hazard to patients. We were told that the practice had planned to replace carpets and flooring in the near future. Immediately following the inspection we were sent evidence to confirm that the carpets were scheduled to be cleaned in June 2017 and we received a quotation for carpeted areas to be replaced with clinically appropriate flooring. However, we did not receive information relating to replacement of the entrance corridor mat.
- There were tears in the seating in the reception area and the chair in the health care assistants clinical room was badly torn and frayed. There were no elbow operated taps in one of the clinical rooms and there was no risk assessment or action plan in place for their use to reduce the risk of infection. Plugs were in all sinks contrary to infection control required standards although these were removed during the inspection.
- We were told that the locum practice nurse was the infection prevention and control lead supported by one of the health care assistants; we saw evidence to show that the practice nurse had undertaken role specific training however training had not been provided for the healthcare assistant although assistance had been offered by the local CCG the practice had not liaised with the local infection prevention teams for support and to keep up to date with best practice.
- We saw evidence of an audit completed on 6 January 2017 which documented a number of concerns and infection control issues. Although we saw some issues had been addressed, we saw no evidence of an action plan with timescales for completion to ensure all issues identified would be resolved. For example, the audit stated that all rooms required the floors and carpets to be cleaned; furniture needed dusting, bins needed to be cleaned inside and out. We found no evidence of actions being allocated to specific individuals or a proposed follow up audit.
- Spillage kits were available however these were found to be out of date. We found two sharps bins that had not been changed since December 2016 and January 2017, exceeding the three monthly requirement for replacement.

There were insufficient arrangements in place for managing medicines, including emergency medicines and vaccines, in the practice to minimise risks to patient safety (including obtaining, prescribing and recording).

- There were processes for handling repeat prescriptions however these processes did not ensure that patients receiving high risk medicines were not followed up to ensure safe prescribing.
- Repeat prescriptions were signed before being dispensed to patients and there was a process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The practice were unable to demonstrate a cohesive system for monitoring patients taking high risk medicines. We carried out a number of searches in patient records which identified the following.
- Out of eight patients who were being prescribed methotrexate, (a medicine used to treat rheumatoid arthritis), four of these patients did not have an up to

date full blood count (FBC) on their patient record. We checked the hospital laboratory system and were reassured that all eight patients had had a recent FBC however the practice were not aware of this and did not have a system in place to reassure themselves that it was safe to issue repeat prescriptions for these patients.

- We reviewed patients prescribed Sulphazine, (used to treat ulcerative colitis, a condition where the bowel is inflamed). We found that 13 out of 26 patients currently being prescribed the medicine had not had a blood test within the required three months at the time the last prescription was issued.
- Of the 16 patients who were prescribed azathioprine, (a medicine used to treat rheumatoid arthritis and other conditions) five of these had not had a full blood count within the recommended timescales of three months; all of these patients had not received a blood test since January 2017 and two of these had last been completed in August and November 2016.
- These findings were not in line with published clinical guidance for these medicines and this lack of monitoring placed patients at risk of harm. Immediately after the inspection, the practice told us that a review of all patients would be carried out.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS with the exception of those non clinical staff carrying out chaperone duties.

Monitoring risks to patients

There were some 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.

- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice.
- There was no risk assessments in place to monitor health and safety of the premises such as legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We saw a legionella policy and a record of regular water testing being undertaken.
- There was no evidence of a health and safety risk assessment. Immediately following the inspection we were sent a copy of a health and safety risk assessment however this was incomplete. The risk assessment was not dated and did not have an action plan in place.
- All electrical equipment was checked in June 2016 to ensure the equipment was safe to use and clinical equipment was also checked in June 2016 to ensure it was working properly. However the practice was unable to provide evidence of a five year electrical wiring certificate.
- One of the medication fridges was overstocked and vaccination boxes were stacked too close to the sides of the fridge. Fridge temperatures were recorded however there was only one thermometer for each fridge. This thermometer had been calibrated to confirm accuracy. A second independent thermometer demonstrates good practice however, the thermometer used had been calibrated to confirm accuracy.
- We witnessed that computer access cards were not always removed when staff left the room and computer screens were not always locked.
- There were arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

Inadequate

Are services safe?

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises 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 medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for contractors and staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff knowledge of and reference to national guidelines were inconsistent. The practice did not have a formal system in place to keep all clinical staff up to date. Current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines were not discussed at clinical meetings. However, we were told that staff accessed guidelines from NICE themselves and used the information to deliver care and treatment that met patients' needs and treatment templates were used within the patient computer records to support this.

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 were 92% of the total number of points available compared with the East and North Herts Clinical Commissioning Group (CCG) average of 96% and national average of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

Performance for diabetes related indicators was comparable to the CCG and national averages. For example,

- The percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c was 64 mmol/mol or less in the preceding 12 months was 64%, where the CCG average was 76% and national average was 78%. Exception reporting for this indicator was 4% compared to a CCG average of 7% and national averages were 13%. (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).
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness in the preceding 12 months was 95% which was comparable to the CCG average of 91% and national average of 90%. Exception reporting for this indicator was 10% compared to the CCG and national averages of 12%.

Performance for mental health related indicators was comparable to the CCG and national averages. For example:

- The percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 90% where the East and North Herts Clinical Commissioning Group (CCG) average was 92% and the national average was 89%. Exception reporting for this indicator was 19% compared to a CCG and national averages of 13%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 81% where the CCG average was 86% and the national average was 84%. Exception reporting for this indicator was 17% where the CCG average was 9% and national average was 7%.

Where the exception rate was higher than the local and national average. We checked the exception reporting system and saw that the practice had a recall system in place and systematic approach for recording exceptions.

There was limited evidence of quality improvement including clinical audit:

- We saw evidence of three clinical audits commenced in the last two years, none of these were completed audits where the improvements made were implemented and monitored. An example of an audit carried out in relation to breast cancer referrals demonstrated that changes were made to the clinical system to alert clinicians to current guidance and referral criteria, a specific clinician was to undergo extended training to carry out the examinations and to reduce anxiety for patients clearer information with options was made available.

There was no evidence that the practice was comparing its performance to others; either locally or nationally.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However we saw evidence that there were gaps in training for staff for example, the health care assistant had not completed safeguarding training.
- 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. The health care assistant, supported by a GP had completed training to monitor some aspects of long term conditions such as diabetic foot monitoring.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work, but some mandatory training modules had not been completed for all staff.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources.
- As part of a local pilot scheme the practice had employed two pharmacists with the support of the local CCG to assist with the management of patients with long term health conditions.

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.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred to, or after they were discharged from hospital.
- Meetings took place with the local Home First team every six weeks. Home First was a service that supported older people and others with long term or complex conditions to remain at home rather than go into hospital or residential care. There were meetings with other health care professionals when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life and palliative care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

The practice and the out of hours service, were able to coordinate patient care through shared care records.

Consent to care and treatment

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

- Staff had received training that included the Mental Capacity Act 2005. They understood the relevant consent and decision-making requirements of the legislation and guidance.
- 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 or practice nurse 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. For example: patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had completed 17 health checks out of 45 patients since July 2016, 15 had declined and 12 had not responded to the invitation. This patient register was

Requires improvement

Are services effective?

(for example, treatment is effective)

managed by a designated staff member who recalled the patient by offering them the option of having a check, this is also explained to them why they are having the check and the reason for their review. Once recalled they were booked in with a health care assistant for a full health check and a GP on the same day for the completion of the check. If the patient was unable to attend the surgery a home visit with both the HCA and GP was arranged. There was no follow up process for those who did not respond.

The practice's uptake for the cervical screening programme was 87%, which was above the CCG average of 83% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

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

- 72% of females, aged 50-70 years, were screened for breast cancer in last 36 months compared to the CCG average of 72% and the national average of 73%.
- 59% of patients, aged 60-69 years, were screened for bowel cancer in last 30 months compared to the CCG average of 60% and the national average of 58%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. The practice achieved above the required 90% standard for childhood immunisation rates between April 2015 and March 2016. For example, 93% of children up to two years of age received their full course of recommended vaccinations and 95% of these children received their Measles, Mumps and Rubella vaccination.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. In the last 12 months 432 of these checks had been completed. The healthcare assistant offered health checks for the over 75 age group 143 checks were completed in the last 12 months.

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that most members of staff were courteous and 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.
- Consultation and treatment room doors were closed during consultations however on the day of inspection the window of the consulting rooms were open and conversations with patients could be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be seen and treated by a clinician of the same sex if required.

Of the 18 Care Quality Commission patient comment cards we received, 12 contained positive comments about the service received and availability of specific GPs. Six responses commented on poor service, lack of access and the poor condition of the premises.

We spoke with five patients during the inspection and of the five patients we spoke with four said it was very difficult to get through on the telephone and to get an appointment. Two said the quality of care varied according to which GP they saw, but all five said they were given enough time during consultations.

Most recent results from the national GP patient survey published July 2016 were significantly lower than the local CCG and national averages and demonstrated that patients did not feel they were treated with compassion, dignity and respect. The practice results were low for its satisfaction scores on consultations with GPs and nurses. For example:

- 59% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 46% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 74% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and the national average of 92%
- 54% of patients 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%.
- 71% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) and national averages of 91%.
- 69% of patients said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 89% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average and national averages of 97%.
- 68% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90%national average of 91%.
- 48% of patients said they found the receptionists at the practice helpful compared with the CCG average of 83% and the national average of 87%.

The practice was aware of these low results and had worked with the patient participation group (PPG) who had devised a similar questionnaire which has been undertaken annually since 2014. The PPG had undertaken a patient survey between March 2016 and May 2016, which focused on the patient experience when receiving care and treatment. Members of the PPG had conducted face to face and telephone interviews with approximately 316 patients. Questions asked were similar to those asked as part of the national GP patient survey. We spoke with a member of the PPG who advised that the results showed a marked difference in the data we had access to. For example,

- 85% of patients interviewed said that reception staff were polite and helpful and 95% said that the GP took time to listen to them. This was not verified data. We saw the report compiled following the survey which stated that the East and North Herts Clinical Commissioning Group and NHS England were aware of the survey.

Although the PPG had worked with the practice and undertaken separate internal surveys, data we had access to was the lowest nationally and we saw no evidence of an improvement plan.

Care planning and involvement in decisions about care and treatment

Although the GP Patient survey results were low, patients told us they felt involved in decision making about the care

and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also reflected these views.

We saw that care plans were personalised for those being treated for end of life and palliative care. The plans were regularly reviewed at multidisciplinary team meetings.

We were told that children and young people were treated in an age-appropriate way and recognised as individuals.

The most recent results from the national GP patient survey published July 2016 showed patients did not respond positively to questions about their involvement in planning and making decisions about their care and treatment. Results were significantly lower compared to local CCG and national averages. For example:

- 46% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 86%.
- 39% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 82%.
- 62% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 53% of patients 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%.

However, patients we spoke to on the day said that they did feel involved in decisions about their care during consultations with both GPs and nurses.

- The practice provided facilities to help patients be involved in decisions about their care:
- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 402 patients as carers (approximately 3% of the practice list). The practice also recorded all patients who had a carer. This enabled staff to ensure that carers who were not patients registered at the practice could be involved in discussions and decisions regarding the person they cared for. There were designated carers notice boards in the waiting area directed carers to the avenues of support available to them.

A member of staff acted as a carers' champion to help ensure that the services supporting carers were coordinated and effective.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. 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.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with NHS England East and North Herts CCG to secure improvements to services.

- Whilst the practice offered some service to address the needs of its population we found access to appointments and consultations to be insufficient.
- For example, we also witnessed a mother trying to get an emergency appointment for a child who was advised to go to the walk in centre and an elderly patient who had come to the practice on three consecutive days to try to get an appointment for a swollen knee.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly and urgent appointments were not available the same day.
- The practice offered extended hours on Monday, Tuesday and Wednesday mornings from 7.30 am and on Monday and Tuesday evenings until 8pm and 7.30pm respectively, for patients who were not able to attend during normal opening hours.
- There were longer appointments available for patients with a learning disability, those experiencing poor mental health or people with dementia.
- Home visits were available for older patients and vulnerable patients who had clinical needs which resulted in difficulty attending the practice. The practice was part of the Home First, Acute Visiting and Rapid Response service.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with patients about their end of life care in addition to their wider treatment and care planning.
- The practice referred patients to 'Kooth' an online counselling and emotional wellbeing service specifically for children and young people.
- The practice sent text message reminders of forward booked appointments and test results.
- Patients were able to receive travel vaccines available on the NHS. Patients were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice was not aware of the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate. However information leaflets detailing support were available in the waiting area.

Access to the service

Patients consistently reported difficulty in getting an appointment. Although extended hours appointments were offered on Monday, Tuesday and Wednesday mornings from 7.30am and Monday and Tuesday evenings until 8pm and 7.30pm respectively, this only equated to six additional appointments in the morning and evening. We checked the number of appointments available and found these to be below the recommended required number.

There was a triage system in place for patients who were vulnerable, small children or elderly, these calls were initially dealt with by the practice manager or senior administrator who would add them to the GP list for review. We saw that not all staff understood the system and gave out the wrong information to patients regarding appointments. We saw that patients were being told that there were no appointments available despite being informed that the GPs would see all patients.Routine appointments could be booked three weeks in advance. Each GP offered four appointments each day that could be booked via the on line system.

A primary care demand and capacity audit was commissioned by the Lower Lea Valley Locality in November 2016 (results published in January 2017).The survey identified that the practice was a significant outlier in terms of patients being asked to call or come back in order to book an appointment for example, where a patient contacted the practice to book an appointment but none was booked) The recommendation was or the practice to review and for them to reduce call backs down, in line with performance at other practices.

In addition the survey demonstrated that the practice had a shortfall of GP and practice nurse consultations per week (which was equivalent to approximately one full time GP). The recommendation was that the practice should consider increasing their workforce so that it was in line with other practices within the locality. The practice told us that this could be achieved in different ways and the practice was in the final stages of recruiting two nurses.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

The survey also identified a high proportion of patients from the practice not using alternative methods of health advice before requesting an appointment. When we spoke to the patient participation group representative we were told that they had worked with the practice and had developed a self-help information leaflet for patients to advice alternative ways of managing health problems that may not require a face to face appointment with a GP.

The most recent results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was significantly lower than local and national averages.

The practice rationale for these poor results was that in 2014 a telephone triage system had been introduced. We were informed that the system had not worked well for staff and patients and the practice felt that this contributed to the low scores. It was noted that this was stopped two years prior to the patient survey results and three years prior to our inspection.

- 45% of patients were satisfied with the practice's opening hours compared with the local clinical commissioning group (CCG) average of 69% and the national average of 76%.
- 14% of patients said they could get through easily to the practice by phone compared to the CCG average of 62% and national average of 74%.
- 47% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 70% and the national average of 76%.
- 74% of patients said their last appointment was convenient compared with the CCG average of 90% and the national average of 92%.
- 25% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 23% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 55% and the national average of 56%.

Of the five patients we spoke to on the day four out of five said they were unable to get a routine appointment and three out of five said they said they were unable to get an emergency appointment.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. The duty GP would contact the patient by telephone in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. If patients required an urgent home visit the practice could refer to the Acute Visiting Service who would arrange for the patient to be seen within 30 minutes. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. In addition the practice was part of a number of local CCG initiatives: Home First, a virtual ward service for elderly patients, the Rapid Response team, who housebound patients can be referred to if they require urgent treatment or tests.

The practice was heavily reliant on these services and for example they relied on them to complete comprehensive care plans to share with the practice. The initiative had been put in place to help the access issues however we observed that this had not solved the access problems for patients.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

The 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. The practice had a comments and complaints leaflet which included information on the Parliamentary and Health Service Ombudsman (the PHSO make final decisions on complaints that have not been resolved by the NHS in England). The practice was unable to demonstrate how they ensured learning from complaints being shared with all relevant staff.

We looked at 15 complaints received in the last 12 months and of the three we looked at in detail we found they were satisfactorily handled in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints but there was no evidence of analysis of trends. We saw evidence that action was taken to as a result of a complaint to improve the quality of care. For example, discussions were held with the reception staff

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

regarding initial assessments of patient need if appointments were not available. The clinical system was adjusted to allow for exceptions and managers discretion to improve the patient experience.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

We found flaws in the leadership and governance of the practice. Formal systems and processes were lacking in many areas.

The practice had a vision to deliver high quality care and promote good outcomes for patients.

They had adopted a mission statement to foster an ethos of continuous improvement. This was not displayed in the waiting and staff areas and staff we spoke to were not clear and did not fully understand the values. The practice was working towards a hub model with the eight practices that they were federated with.

Governance arrangements

The practice lacked an adequate overarching governance framework to support the delivery of good quality care.

- There was no programme to ensure continuous clinical and internal audit had not been completed to monitor quality and to make improvements.
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were all done informally and some risk assessments had not been completed. For example, there was no legionella risk assessments completed and the health and safety risk assessment was incomplete and not dated.
- The infection control audit had been completed in January 2017 but there was no action plan or follow up audit process in place. Issues identified had not been addressed.
- Although staff had received annual appraisals, some essential staff training had not been completed.
- Regular practice meetings were held where clinical matters were discussed, however we did not see a systematic approach for learning to be shared with staff including significant events and complaints.
- Practice specific policies and procedures were available to all staff. However, some staff we spoke to did not know how to access them. For example one GP was unable to locate the repeat prescribing policy.

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 monitoring risks to patients for example, there was no legionella risk assessment or complete health and safety risk assessment in place. The practice also had not followed up on actions identified in the infection control audit which had resulted in the lack of cleanliness within the practice.
- 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 follow up infection control auditing.
- The practice's process for identifying and recording significant events was effective; however there was not dissemination of information to staff or analysis of significant events over time to identify trends.
- The practice had failed to identify risks to babies if parents used the changing unit available and had no reactive plan in place to replace the torn matting in the entrance corridor.
- Whilst the practice had practice specific policies, some staff were unaware of how to access them on the electronic system.

Leadership and culture

During our inspection we identified an overarching lack of leadership to understand all aspects of the practice.

- The practice was led by the four GP partners with the support of the practice manager. The partners had lead roles in aspects of the management of the practice for example, HR and finance, with overarching responsibilities for health and safety, however it was not evident that this system was cohesive. 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). We spoke to a member of the clinical team who was not able to give a clear explanation of the duty of candour and did not appear to have a good understanding.

Are services well-led?

Inadequate

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

- Staff had received training and were aware of how to report notifiable safety incidents however the practice did not share information with all staff.
- The practice kept records of written and verbal correspondence and gave affected people support and a verbal and written apology. From the sample of four documented examples we reviewed we found that the practice had systems in place to ensure that when things went wrong with care and treatment these were recorded and acted upon in a timely manner but the learning from these incidents was not shared with all staff and there was no evidence of analysis of trends.
- We saw evidence that regular meetings were taking place for all staff groups including, weekly clinical meetings, quarterly more informal staff meetings and multidisciplinary team meetings with community staff.
- The practice were part of a federation with eight other GP practices in the locality. The federation aimed to provide local NHS GP Practices and was working towards a hub set up that would enabled them to pool resources and work in partnership with other NHS and provider organisations to effectively and locally deliver innovative, integrated, accessible high quality services to their residents.

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

The practice valued feedback from patients, the public and staff but they had not proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had an established patient participation group (PPG) and we were told they engaged well with the practice and acted as 'critical friend'. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had assisted in the development of a self-help leaflet for patients.
- The national GP patient survey demonstrated significantly and consistently low scores. The PPG had developed and undertaken a survey to gauge the responses, but the management team were not proactive in addressing the issues raised by the outcome of the original survey.
- The practice had Family and Friends Test response cards in the patient waiting area but there had been none completed since 2014. We saw evidence that poor response had been discussed at practice meetings and reception staff were asked to encourage patients to complete the survey forms however none had been received.
- The practice had gathered feedback from staff through appraisals and informal discussion. Staff told us they gave feedback and would discuss any concerns or issues with colleagues and management.

This section is primarily information for the provider

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, 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. Not all staff had received infection control training in particular those who were identified as the leads for the role. Infection control audits had been undertaken but actions identified had not been carried out and there was no action plan in place. Systems to ensure appropriate management and monitoring of infection prevention were insufficient to ensure that the premises are kept to an appropriate standard of cleanliness and repair. We found no evidence of a 5 year electrical certificate. PAT testing and calibration had been undertaken but there was no equipment maintenance schedule in place. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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:** There was a lack of adequate governance arrangements and risk assessments particularly in relation to Health and Safety and Legionella.

This section is primarily information for the provider

Enforcement actions

Staff were not aware of where to access policies and procedures to enable them to carry out their roles safely and effectively.

SMART cards were not always removed when staff left the room and computer screens were not always locked.

Information regarding the outcomes and learning from significant events and complaints was not communicated to all staff.

There was no formal system in place to keep all clinical staff up to date. This omission was not identified by an effective system or process established to ensure compliance with the requirements.

Failure to address poor national GP patient survey data.

There was a lack of awareness and understanding in terms of responsibilities to the duty of candour.