Keyhealth Medical Centre

Quality Report

Waltham Abbey Health Centre
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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?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Keyhealth Medical Centre on 22nd August 2017. Overall the practice is rated as inadequate.

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

- There was not a transparent approach to safety. The system for learning from and actioning significant events was not effective.
- Searches were not being routinely undertaken to identify patients who may be at risk as a result of Medicine and Healthcare products Regulatory Agency (MHRA) alerts.
- There were not adequate systems in place to manage and respond to pathology results.
- Not all staff were trained in adult or child safeguarding. The safeguarding vulnerable adults' policy did not identify a lead member of staff.
- The practice manager had experience of dealing with patients who had experienced issues with drug and alcohol misuse and utilised skills to involve patients in their care.
- Not all chaperones were trained, DBS checked or risk assessed as to their suitability to the role.
- The practice maintained appropriate standards of cleanliness and hygiene, although actions identified in the infection control audit had not been completed.
- Recruitment checks were not consistently applied.
- The system in place to ensure that clinical staff were following NICE guidance was not effective.
- The practice did not monitor the use of prescription stationery around the practice, although prescription stationery was stored securely.
- Staff had not received training in health and safety, infection control or basic life support.
- Staff did not have the skills and knowledge to support the delivery of effective care.
- There were not effective systems in place to share information with other providers.

Summary of findings

- Patient feedback was variable about the care received at the practice. National GP patient survey results published in July 2017 showed that the practice was performing in line with CCG and national averages in respect of consultations with the nurse, and in line with or below CCG and national averages in respect of consultations with the GPs.
- There were no processes in place to support carers. 0.9% of patients who were carers had been identified.
- There were 20 patients on the learning disabilities register and two had received a health check in the last year.
- The practice did not monitor inadequate cervical smear rates. The nurse was not aware of any failsafe procedures which sought to ensure an effective sample was taken.
- Patients said there was a lack of consistency and presence of GPs and that they experienced difficulties obtaining appointments.
- Information about how to complain was not easily available to patients.
- The practice team was not strong. There was a lack of presence and leadership by the lead GP and the administration workforce as a whole were not settled or embedded into their roles. Clinical staff were transient: nurses were self-employed and all GPs, aside from the lead GP, were locums.

The areas where the provider must make improvement are:

- Ensure effective systems and processes are established in relation to good governance in accordance with the regulations and fundamental standards of care.
- Ensure care and treatment is provided in a safe way to patients
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Ensure the issues highlighted in the national GP patient survey are addressed in order to improve patient satisfaction, including concerns relating to appointment access and consultations with GPs.

The areas where the provider should make improvement are:

- Complete actions identified as required in the infection control audit.
- Update the safeguarding adults' policy to identify the lead clinician responsible for safeguarding.
- Improve the identification of carers in order to provide them with appropriate support.
- Make available information about how to make a complaint, the availability of chaperones and the changes to the provider.

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 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.

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.

- Action taken from significant events was not always clear or effective.
- There was a lack of meaningful information cascade and evidence of learning. There were no clinical meetings involving the nurses or the GPs.
- The system to act on Medicine and Healthcare products Regulatory Agency (MHRA) alerts was not effective. Searches were not being routinely undertaken to identify patients at risk.
- Not all staff were trained in adult or child safeguarding. The safeguarding vulnerable adults' policy did not identify a lead member of staff.
- Not all chaperones were trained, DBS checked or risk assessed as to their suitability to the role.
- The practice maintained appropriate standards of cleanliness and hygiene, although actions identified in the IPC audit had not been completed.
- Recruitment checks were not consistently applied.
- The practice did not monitor the use of prescription stationery around the practice.
- Clinical and non-clinical staff had not received training in infection control, health and safety or basic life support.
- The arrangements for storing emergency medicines and equipment required review to ensure that these were secure.
- Patients prescribed high risk medicines were being monitored.

Are services effective?

Inadequate

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

- The current provider had been registered with the Care Quality Commission since May 2017 and had been providing services since December 2016. Unverified data from the year 2016 to 2017 indicated improvements had been made since the previous year, although this continued to indicate that patient outcomes were below average.
- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- There was limited evidence of quality improvement including clinical audit. The system in place to ensure staff were following NICE guidance was not effective.

Summary of findings

- Staff did not have the skills and knowledge to enable them to support in the delivery of effective care and treatment.
- There had been no meetings with other health and social care professionals although it was anticipated a care co-ordinator would be holding regular meetings at the practice in the month following our inspection.
- Pathology results were not being effectively managed.
- There were 20 patients on the learning disabilities register and two had received a health check in the last year.

Are services caring?

Requires improvement

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

- Patient feedback was variable about the care received at the practice. GP survey results showed that the practice was performing in line with CCG and national averages in respect of consultations with the nurse, and in line with or below CCG and national averages in respect of consultations with the GPs.
- Some information for patients about the services available was displayed in the waiting room, although the practice website was under construction.
- We saw reception staff treat patients with kindness and respect, whilst maintaining patient and information confidentiality.
- The practice manager had experience of dealing with patients who had experienced issues with drug and alcohol misuse and utilised skills to involve patients in their care.
- The practice had identified 58 patients as carers on its systems although they did not offer any additional services for carers. This represented 0.9% of the patient list size.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- Patients said there was a lack of consistency and presence of GPs and that they experienced difficulties obtaining appointments.
- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages.
- Car parking was available at a nearby car park.
- Appointments were provided from 9am until 6.20pm every weekday.
- Appointments with a GP, nurse or healthcare assistant were available at the GP hub on a Friday evening and on weekends.

Summary of findings

- A permanent GP was available on a Wednesday morning to review complex patients. Most of these appointments could not be booked without prior consent from the GP.
- The practice website was under construction.
- Information about how to complain was not easily available to patients.
- Evidence from five examples reviewed showed the practice responded quickly to issues raised, although there were not effective systems to review and learn from complaints.

Are services well-led?

Inadequate

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

- The provider was not delivering high quality, effective treatment and had not implemented their visions and strategy.
- The provider was working towards improvement since taking on the running of the practice in 2016 but had not taken sufficient action to identify and act on risks to patients and staff.
- There was a lack of presence and leadership by the lead GP.
- There was no regular clinical meeting where information such as MHRA alerts, patients of concern, NICE guidelines and significant events and complaints, for example were considered. Information cascades were not effective.
- It was unclear how new staff were to be embedded into their role due to the absence of any scheduled training, review, appraisal, support or allocated time for development.
- The practice worked largely in isolation and did not engage with practices or stakeholders in the locality.

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 the care of older people. The provider has been rated as inadequate for providing safe, effective and well-led services and requires improvement for providing caring services. The ratings apply to all patients using this service, including this population group.

- Staff had not received training in safeguarding vulnerable adults. The safeguarding vulnerable adults' policy did not provide details of the lead member of staff.
- There were not effective systems to share information about older people who may need palliative care as they were approaching the end of life.
- There were a lack of regular GPs working at the practice, and patients raised concern about the lack of continuity of care.
- Pathology results were not being managed effectively.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The provider has been rated as inadequate for providing safe, effective and well-led services and requires improvement for providing caring services. The ratings apply to all patients using this service, including this population group.

- Whilst the practice had evidenced some improvement in outcomes for people with long term conditions since they had taken over the practice, outcomes continued to be below the local and national average
- There were no meetings of nurses to discuss patients who had long term conditions. There were not effective systems to share information with other providers when concerns were identified with patients who had long-term conditions.
- The lead GP held a surgery for one morning per week. This time was protected to review complex patients with long-term conditions.
- There was a lack of regular GPs working at the practice, and patients raised concern about the lack of continuity of care.
- Pathology results were not managed effectively.

Summary of findings

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider has been rated as inadequate for providing safe, effective and well-led services and requires improvement for providing caring services. The ratings apply to all patients using this service, including this population group.

The ratings apply to all patients using this service, including this population group.

- Unverified data for 2016/2017 showed that the practice's uptake for the cervical screening programme was 76%. Verified data relating to CCG and national averages was not yet available. The practice did not monitor inadequate cervical smear rates. The nurse was not aware of any failsafe procedures which sought to ensure an effective sample was taken.
- Administrative staff were not trained in safeguarding children. There was no evidence of safeguarding children training for one GP locum engaged at the practice.
- There were not effective systems to share information with other providers when concerns were identified with children and young people.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people (including those recently retired and students). The provider has been rated as inadequate for providing safe, effective and well-led services and requires improvement for providing caring services. The ratings apply to all patients using this service, including this population group.

- Appointments ran from 9am until 6.20pm every weekday evening.
- Appointments with a GP, nurse or healthcare assistant were available at the GP hub on a Friday evening and on weekends.
- There was a range of health promotion and screening available that reflected the needs of this population group.
- Health and well-being checks were available with the nurse.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider has been

rated as inadequate for providing safe, effective and well-led services and requires improvement for providing caring services. The ratings apply to all patients using this service, including this population group.

- There were 20 patients on the learning disabilities register. The practice had completed health checks for two of these patients in the last year.
- The practice manager had experience of dealing with patients who had experienced issues with drug and alcohol misuse. We observed them utilising their skills to support relevant patients to access the practice, using sensitivity and discretion.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 58 patients as carers on its systems which was 0.9% of the patient population. The practice did not offer any additional services for carers.
- End of life care was not delivered in a coordinated way as there was a lack of systems to share information with other providers.
- Staff had not received training in safeguarding vulnerable adults.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The provider has been rated as inadequate for providing safe, effective and well-led services and requires improvement for providing caring services. The ratings apply to all patients using this service, including this population group.

- The practice did not work with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Staff had not received training in safeguarding vulnerable adults.
- Staff were aware of the mental capacity act. A GP locum who worked at the practice had a special interest in supporting patients who were experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. Surveys were sent to patients in January 2017. The results showed the practice was performing below CCG and national averages in respect of accessing the service, in line with CCG and national averages in respect of consultations with the nurse, and in line with or below CCG and national averages in respect of consultations with the GPs. 298 survey forms were distributed and 120 were returned. This represented a completion rate of 40%.

- 10% of patients usually got to see or speak to their preferred GP compared with the CCG average of 51% and national average of 56%.
- 67% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 56% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 55% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and national average of 77%.
- 91% of patients said that last nurse they saw or spoke to was good at explaining tests or treatments compared to a CCG and national average of 90%.
- 64% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 82%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards. 12 of these were positive, with patients praising the reception and clinical staff. Eight of these were less positive, with patients telling us that there was a lack of consistency and presence of GPs and that they experienced difficulties obtaining appointments.

We spoke with four patients during the inspection. Three patients told us that there was a lack of continuity of GPs. Two patients told us that they had difficulty in getting through on the phone. All patients were complimentary about the care received from the nurses.

During the course of the inspection, we spoke with a local community representative who expressed concern about the practice. They provided us with a list of signatures from 36 patients who signed to indicate their dissatisfaction at the lack of clinical staff and difficulty in accessing appointments.

Areas for improvement

Action the service MUST take to improve

- Ensure effective systems and processes are established in relation to good governance in accordance with the regulations and fundamental standards of care.
- Ensure care and treatment is provided in a safe way to patients
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Ensure the issues highlighted in the national GP patient survey are addressed in order to improve patient satisfaction, including appointment access and those in relation to consultations with GPs

Action the service SHOULD take to improve

- Complete actions identified as required in the infection control audit.
- Update the safeguarding adults' policy to identify the lead clinician responsible for safeguarding.
- Improve the identification of carers in order to provide them with appropriate support.

Summary of findings

- Make available information about how to make a complaint, the availability of chaperones and the changes to the provider.

Keyhealth Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist advisor, a second CQC inspector, and a practice nurse specialist advisor.

Background to Keyhealth Medical Centre

Keyhealth Medical Centre is located in Waltham Abbey, Essex. It provides GP services to approximately 6,200 patients living in the locality. It is situated next to a supermarket and patients can use the parking facilities. The practice shares its premises with another GP practice and other community services.

Operon Health Limited runs Keyhealth Medical Centre and has been registered since May 2017 and provided services at the practice since December 2016.

The director and only permanent GP works at the practice one day a week, the remainder of the week he works away from the practice and accesses the systems remotely from an office. There are three long-term locums engaged, four nurse practitioners and three practice nurses. Nurses are engaged on a self-employed basis.

The provider is supported by a full-time practice manager who has been working at the practice since June 2017. They are supported by reception and administrative staff, a number of whom have been recruited since the new provider took over the practice.

The practice is open between 8am until 6.30pm Monday to Friday. Appointments are from 9am to 1.50pm every morning and 3pm to 6.20pm daily. Appointments for the hub, which is open on the weekends and a Friday evening, can be booked at reception.

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 visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22nd August 2017

During our visit we:

- Spoke with a range of staff including the practice manager, nurse practitioner, two receptionists and a locum GP. We also spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.

Detailed findings

- 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

The procedure for reporting and learning from significant events was not effectively embedded into the provider's systems. Administration staff were unsure of the system for managing significant events, although they told us they would raise any issues with the practice manager or GPs.

- We looked at six significant events raised since the current provider had taken over the NHS contract in December 2016. These related to clinical and non-clinical risks identified on taking over the contract as well as issues that had presented since the beginning of the year.
- Action taken from significant events was not always clear or effective. For example, whilst we saw evidence that action had been taken in response to a significant event concerning the monitoring of fridge temperatures and systems improved, other actions from significant events remained outstanding; for example, in December 2016 – February 2017, there was an action to recruit an employed clinical team. At the date of our inspection, the clinical team were engaged on a locum or self-employed basis and the practice were not advertising for the recruitment of permanent clinical staff. Patients continued to raise concern with the lack of continuity of care.
- There was a lack of meaningful information cascade. There were limited systems to share learning and information, such as NICE guidelines, MHRA alerts and learning from significant events. The weekly senior management team meeting was attended by the GP director and practice manager. There was no regular meeting to include the nurses, regular locum GPs and administrative team so systems to learn and share information were not effectively embedded.
- The system to act on Medicine and Healthcare products Regulatory Agency (MHRA) alerts was not effective as searches were not being routinely undertaken to identify patients at risk. Although we were informed these were emailed to all clinicians, there was no means whereby these emails would be acknowledged as actioned. The practice had not completed a search in relation to one MHRA alert which related to the prescribing of a certain medicine to women who had epilepsy and were of child bearing age. Whilst inspectors carried out a search and no patients were identified as being at risk, this search had not been undertaken by the practice at the time of the alert to ensure risks were mitigated.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Permanent GPs were trained to safeguarding level three. We looked at three files for locum GPs who were engaged at the practice. There was no evidence of safeguarding children training for one locum GP and no evidence of safeguarding vulnerable adults training for another. The practice did not know whether these locums had received this training.
- Administrative staff who had contact with patients had not yet received safeguarding training. A number of these staff had been recently recruited by the new provider and we were informed that training would be provided in the summer months. This was in accordance with the provider's safeguarding policy which stated that safeguarding training would be provided within six months of the employment start date. However, this training had not been provided to staff who had worked at the practice for longer than this period, either.
- Policies were accessible to all staff. Whereas the safeguarding children policy identified a lead member for staff responsible for safeguarding, this was not the case on the safeguarding adults' policy.
- There were no notices advising patients that chaperones were available if required. We looked at the records of three members of staff who acted as chaperones. There was no evidence that these staff members had received training. Whereas we saw that a DBS check had been requested for one member of staff who acted as chaperone, there were no DBS checks present for the other two members of staff. There was no risk assessment to ascertain their suitability for the role in absence of a 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). There was a risk assessment completed after the inspection relating to the use of untrained chaperones, although this did not relate to the lack of

DBS checks. Further, the practice sent us a copy of a poster that they were intending to use to advise patients as to the availability of chaperones. Some staff spoken with who acted as chaperones, were not aware of the correct procedures to follow when present at consultations.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy.
- The practice nurse was the infection prevention and control (IPC) clinical lead. There was an IPC protocol and nursing staff had received up to date training. Administrative staff were yet to complete infection control training. Annual IPC audits were undertaken although action plans remained outstanding.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable 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. Blank prescription forms and pads were securely stored although systems to monitor their use in the practice required improvement. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed the personnel files of three staff recruited since the beginning of the year. Appropriate recruitment checks had not been undertaken prior to employment. For example, there was no proof of identification or evidence of satisfactory conduct in previous employments in the form of references for one member of staff.

Monitoring risks to patients

The procedures for assessing, monitoring and managing risks to patient and staff safety required improvement.

- Staff had not received training in health and safety. Training for staff had been planned to take place during the summer months but was yet to take place.
- The practice had an up to date fire risk assessment.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- On the day of our inspection, the reception team was short-staffed due to unforeseen circumstances. We observed the practice manager assisting with reception duties in order to meet patient demand. Whilst the practice had experienced a number of changes to the administration team since the new provider had taken over, new staff had and were in the process of being recruited.

Arrangements to deal with emergencies and major incidents

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

- Staff had not received annual basic life support training.
- There were emergency medicines and equipment 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.
- 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 staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the new provider had improved systems of monitoring patients prescribed certain medicines in line with NICE guidelines since taking over the practice. However, whilst we were informed clinicians were emailed with relevant updates, there was no system whereby the provider would monitor to ensure that updated clinical guidance had been received. There was no regular clinical meeting where new guidelines could be discussed.

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).

QOF data is collated on an annual basis, starting and ending in April. Data is published in the following October. The current provider became the registered provider with the Care Quality Commission in May 2017. The director of the company provider took over the contract with NHS England in December 2016 and as such, the provider did not have responsibility for the full QOF year 2015/2016.

Unverified data for the year 2015/2016 showed the practice had achieved 303 points out of a possible 559. Although this indicated underperformance, evidence was provided to show that some improvements had been made from the year 2016/2017 and the practice had achieved 395 points. CCG and England averages were not available for comparison. Unverified data showed:

- The percentage of patients with asthma who had an asthma review in the preceding 12 months was 59%. In the preceding year, this was 9% which was 64% below the CCG average and 66% below England average.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a care plan documented in the record in the 12 months was 75%. In the preceding year, this was 9% which was 79% below the CCG average and 80% below England average.
- .The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 59%. In the preceding year, this was 11% which was 77% below the CCG Average and 78% below England average.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to face review in the preceding 12 months was 61%. In the preceding year, this was 27%, which was 54% below CCG average and 57% below England average.
- The percentage of patients with diabetes who had received a blood pressure check within given levels was 57%. In the preceding year, this was 62% which was 27% below CCG average and 30% below England average.
- The percentage of patients with diabetes whose cholesterol was within specified limits was 50%. In the preceding year, this was 54%, which was 23% below CCG average and 27% below England average.

There was limited evidence of quality improvement including clinical audit, although some areas of unverified data as above indicated that the provider had begun to address areas of underperformance.

The practice had completed one audit since the beginning of the year which looked at prescribing emollient cream. It had been noted that clinical time was being spent writing acute prescriptions for emollient cream and therefore, relevant patients were given repeat prescriptions for this. There was no evidence of other audits being planned.

Effective staffing

The provider was in the process of recruiting a full administrative team. A number of staff had left and been recruited since the provider took over the practice. The practice manager had been recruited in the weeks prior to our inspection and staff did not have all of the skills and knowledge to deliver effective care and treatment:

- The practice had an initial induction for new staff. This included shadowing an experienced member of staff and orientation around the premises.
- New staff informed us they were due to complete online training in the days that followed our inspection. The practice had devised a matrix which detailed the training that staff would be undertaking in the coming months. This was not complete.

Inadequate

Are services effective?

(for example, treatment is effective)

- Appraisals were yet to take place for clinical or non-clinical staff, although the provider had not yet been at the practice for a year. The practice manager informed us that appraisals for non-clinical staff were to be scheduled in the months following our inspection, and regular staff meetings were to take place on a bi-weekly basis. There were no dates provided for appraisals of the nursing team. Nurses did not receive regular supervision.

Coordinating patient care and information sharing

There had been no meetings with other health and social care professionals since the provider had taken over the practice. There was no other evidence of the practice working with other organisations to promote information sharing and care planning. It was anticipated that a care co-ordinator would be holding regular meetings at the practice in the month following our inspection and further, that multi-disciplinary meetings would take place with Essex Ambulance, social workers from the adult social care team and district nurses. The care co-ordinator's role is to share information and co-ordinate care between professionals for patients with complex needs.

The practice was working with CCG pharmacy teams one day a week to review prescribing. The clinical director reviewed two week wait referrals and there were systems in place which sought to ensure that these were effective. However, we noted that there were 117 pathology results that had not been actioned since 31 July 2017, over a month prior to our inspection. We were informed that this was because these related to patients who had left the practice and results were being sent to the practice in error. We were sent evidence after the inspection to confirm that these pathology results had since been actioned.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Supporting patients to live healthier lives

Unverified data for 2016/2017 showed that the practice's uptake for the cervical screening programme was 76%. Verified data relating to CCG and national averages was not available. The practice did not monitor inadequate smear rates. The nurse was not aware of any failsafe procedures.

There were 20 patients on the learning disabilities register. The practice had completed health checks for two of these patients in the last year.

After the inspection, the practice emailed to advise us that they would be starting the Care Navigator service from 12th September 2017. This was to be a weekly service to help people manage their weight, diet and exercise and provide support with smoking cessation.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and helpful to patients.

- 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; conversations taking place in these rooms could not be overheard.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards and responses were mixed. 12 of these were positive, with patients praising the reception and clinical staff. Eight of these were less positive, with patients reporting a lack of continuity of care or reporting concerns with their care and treatment. We spoke with four patients during the inspection. All of these patients were complimentary about the care received by the nurses.

The national GP patient survey results were published in July 2017. Surveys were sent to patients in January 2017. The results showed the practice was performing in line with CCG and national averages in respect of consultations with the nurse, and in line with or below CCG and national averages in respect of consultations with the GPs. 298 survey forms were distributed and 120 were returned. This represented a completion rate of 40%.

- 10% of patients usually got to see or speak to their preferred GP compared with the CCG average of 51% and national average of 56%.
- 67% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 55% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and national average of 77%.
- 91% of patients said that last nurse they saw or spoke to was good at explaining tests or treatments compared to a CCG and national average of 90%.
- 64% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 82%.

Whilst it was noted that the GP surveys were sent to patients to complete shortly after the GP provider had taken over the practice, at our inspection patients continued to raise concerns with the care provided.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed there was mixed responses from patients in relation to their involvement in planning and making decisions about their care and treatment. Results were below or in line with local and national averages. For example:

- 75% 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%.
- 64% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 79% the national average of 82%.
- 91% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 90% and national average of 85%.

The practice carried out their own in-house survey over July and August 2017. They received 33 responses. This questionnaire asked patients two questions: whether the practice was able to deal with their issue, and what other services patients would like to be provided. 26 patients said that the practice was able to deal with their issue and 7 said they did not. Additional services requested by patents included weight loss, mental health and smoking cessation services, for example. Patients also said that they would like to get an appointment when they needed one and see more regular staff. In their action plan, the practice told us that they hoped to provide additional services in the future, such as smoking cessation and an emergency care practitioner so that they could respond to additional pressures during Winter months.

There were no questions which sought to evaluate the standards of care received, as asked in the GP Patient survey and therefore direct comparisons could not be made. The practice had drafted an action plan in response to their own survey. In this, the practice stated that there

Requires improvement

Are services caring?

was no longer a problem with access to appointments for any type of clinical staff member. This did not correlate with feedback received during the course of our inspection, where patients raised concern with the continuity of care.

The practice provided some 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. There were no notices informing patients that this service was available.
- Information leaflets were available in the reception area.
- The waiting area was shared with another GP provider. There was a sign in the waiting area advising patients that services were now provided by Operon Health Limited, although patients were unclear about what this meant. Some explanation was provided in the practice leaflet about the recent changes at the practice, although this did not explain that services were provided by Operon Health Limited.

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. There was no practice website, although we were informed that this was being implemented. The practice leaflet advised patients to access further information on the practice website, but this was still under construction.

The practice manager had experience of dealing with patients who had experienced issues with drug and alcohol misuse. During the course of the inspection, we observed them utilising their skills to support relevant patients to access the practice, using sensitivity and discretion.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 58 patients as carers on its systems and this was 0.9% of the patient population. The practice did not offer any additional services for carers.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The new provider had not considered the practice profile and therefore had not used this to meet the needs of the practice population. The company director, as lead GP was currently in attendance at the practice one day a week, and for the remainder of the week sought to assess the needs of the practice population remotely, by way of email, tasks and information systems. There was an absence of meetings and effective information cascade with clinical and administrative staff, and effective action in response to concerns from patients in respect of access and continuity of care.

Access to the service

The practice was open between 8am until 6.30pm Monday to Friday. Appointments were from 9am to 1.50pm every morning and 3pm to 6.20pm daily. Appointments were available on the weekends and on a Friday evening at a local 'hub' which was provided by a federation of GPs with the support of the CCG. These appointments could be booked at reception.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages.

- 47% of patients said they could get through easily to the practice by phone compared to the CCG average of 62% and national average of 71%.
- 10% of patients said that they usually got to see or speak to their preferred GP compared with the CCG average of 51% and national average of 56%.
- 63% of patients said their last appointment was convenient compared with the CCG average of 80% and the national average of 81%.
- 56% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 45% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 64%.
- 67% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 55% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 55% and national average of 77%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards. 12 of these were positive, with patients praising the reception and clinical staff. Eight of these were less positive, with patients telling us that there was a lack of consistency and presence of GPs and that they experienced difficulties obtaining appointments.

We spoke with four patients during the inspection. Three patients told us that there was a lack of continuity of GPs. Two patients told us that they had difficulty in getting through on the phone. During the course of the inspection, we spoke with a community representative who expressed concern about the practice. They provided us with a list of signatures from 36 patients who signed to indicate their dissatisfaction at the lack of clinical staff and access to appointments.

Listening and learning from concerns and complaints

The practice had received 21 complaints since taking over the practice. We reviewed five of these in detail. These were complaints that had been made more recently. We saw that patients received an acknowledgement of their complaint which was followed up by a detailed response. Responses were written by clinical staff as appropriate and complied with the duty of candour.

We reviewed the complaints log from the beginning of the year. We found that 15 of these complaints related to access issues, in accordance with the feedback we received during the course of our inspection and as detailed in the GP patient survey. Whilst these complaints were responded to on an individual basis, there was a lack of review, action, shared learning and implementation of effective systems to resolve the complaints raised.

Staff were unclear as to how to report complaints and there was no information about making a complaint either at reception or displayed in the waiting area. As there was no website, information about how to make a complaint could not be accessed online, either.

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

In the statement of purpose, the practice advocated providing high quality, effective treatment and advice in safe surroundings. In this, they also declared that the practice comprised of a strong and committed team of people who were working together with the common aim of providing excellent healthcare services to the population of Waltham Abbey.

Last year's QOF data (2015 to 2016) indicated that whereas there had been inherited issues with performance and monitoring, sufficient improvements had not been made by the current provider: action plans had not been put in place to achieve overarching and sustained improvement and intentions were often vague, with a lack of dates and commitment to implementation and review.

Governance arrangements

The provider had been registered with the Care Quality Commission since May 2017 and had held the NHS contract since December 2016. On the day of the inspection we looked at the performance of the practice prior to the new provider being registered with the Care Quality Commission and compared it with the period in which the current provider had been responsible for the practice.

The provider sought to focus on immediate areas of identified risk since taking over the practice, namely improving QOF performance and implementing systems to monitor patients taking high-risk medicines. Whilst some policies and procedures had been created, these had not been effectively implemented and did not underpin safe systems or an effective information cascade:

- There was a lack of presence and leadership by the lead GP and the administration workforce as a whole were not settled or embedded into their roles.
- Many staff from the previous provider had left and new members of the team were being recruited. Training dates were set for the summer months, with no specific dates arranged. The practice manager had been recently recruited with a view to providing more informed oversight and leadership, although they themselves still required training for the role.
- There was a weekly meeting of the senior management team, which considered general administrative and practice issues. There was no regular clinical meeting where information such as MHRA alerts, patients of concern, NICE guidelines and significant events and complaints, for example, could be considered. Information cascades were not effective.
- There were no systems to support nurses. There was no regular meeting of nurses, nor did they receive a regular appraisal.
- Administrative staff that we spoke with had very recently been recruited and so we could not effectively ascertain their understanding of policies and procedures. These were available on the shared drive. Whereas the safeguarding children policy identified a lead member for staff responsible for safeguarding, this was not the case for the safeguarding adults' policy.
- Due to the lack of established information cascade and meeting structures, it was unclear whether learning from MHRA alerts, significant events and complaints was being shared.
- There was limited evidence of quality improvement including clinical audit, although unverified data as above indicated that the provider had begun to address some areas of underperformance.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The provider conducted a range of risk assessments at the premises, such as legionella and health and safety risk assessments. However, some risks were not being managed effectively.

Leadership and culture

The leadership at the practice was inconsistent and transient, as was the clinical team as a whole. None of the clinical team were directly employed by the provider organisation and there was no clear leadership or means to cascade information by way of regular meetings. Nurses were self-employed and all but one of the GPs (being the lead GP) were locums. Patients continued to raise concern with the lack of continuity of care and seeing different GPs at the practice.

The lead GP worked at the practice one day a week, and otherwise sought to provide oversight remotely at an office off-site, where they could access systems. During their day at the practice, the lead GP saw eight patients with complex health needs in the morning and held a senior management team meeting in the afternoon. For a majority of appointments with the lead GP, receptionists

Are services well-led?

Inadequate

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

were required to seek prior authorisation before booking these in. Following the inspection, the provider informed us that they had modified the booking system with a view to making this more effective and that they saw 10-12 patients each Wednesday.

Whilst practice staff told us that they felt supported, there was a lack of systems and time to receive and act on staff feedback to ensure that issues were effectively managed. Many of the practice team were newly appointed, including the practice manager, and it was unclear how they were to be embedded into their role due to the absence of any scheduled training, review, appraisal, support or allocated time for development. There was a lack of systems to support and promote learning, openness and transparency.

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

The national GP patient survey results were published in July 2017. Surveys were sent to patients in January 2017. One of the primary concerns raised by the GP was the lack of ability to see or speak with a preferred GP. Whilst it was noted that the GP surveys were sent to patients to complete shortly after the GP provider had taken over the practice, at our inspection, patients continued to raise concerns with the continuity of care provided and accessing appointments. Furthermore, these concerns continued to be raised by patients during complaints. The provider had acknowledged the need for a stable clinical team during its significant event reporting at the beginning of 2017, and yet there was no evidence of the provider proactively seeking to recruit permanent clinical staff.

There was no patient participation group, although we were informed that the practice was seeking members. In the practice leaflet, the practice asked interested patients to visit the website for more information, which was still yet to go live as of the date of our inspection.

Continuous improvement

The practice worked largely in isolation and did not engage with practices or stakeholders in the locality. There were limited opportunities for learning both internally and externally which was partially due to the lack of effective systems for information cascade.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: Staff were yet to receive an annual appraisal or appropriate other means of ongoing support. Training relevant to the role had not been provided. This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: Pathology results were not being regularly reviewed and actioned. Appropriate action was not consistently taken in relation to significant events. Patients who may be at risk due to MHRA alerts were not being routinely identified. Chaperones were not trained. Recruitment checks of staff were not consistent. Staff were not trained in safeguarding adults or children from abuse. There was ineffective information cascades to identify patients who may be at risk and promote learning and information sharing. This was in breach of regulation 12(1) (2) 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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service

This section is primarily information for the provider

Enforcement actions

users and others who may be at risk, namely by failing to review pathology results in a timely manner, having ineffective systems to manage MHRA and patient safety alerts.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular:

There was no action plan to improve performance following the results of the GP patient survey.

There was no patient participation group and ineffective means of recruiting new members as the practice information leaflet directed patients to a website that was not yet operational.

There was additional evidence of poor governance. In particular:

A lack of systems to share information, learning and risks at the practice.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.