Essex Lodge

Inspection report

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

Ratings

Overall rating for this location	Not sufficient evidence to rate
Are services safe?	**Not sufficient evidence to rate**
Are services effective?	**Not sufficient evidence to rate**
Are services well-led?	**Not sufficient evidence to rate**

Overall summary

Letter from the Chief Inspector of General Practice

We first carried out an announced inspection of Essex Lodge on 29 February 2016 and the practice was rated as requires improvement for providing safe and effective services, good for caring and responsive services and requires improvement overall. We then carried out a follow up focused inspection on 24 April 2017 to consider whether sufficient improvements had been made for provider to meet legal requirements and associated regulations. The practice was rated as good for providing safe services, requires improvement for effective services due to a breach of regulations, and good overall.

This inspection was an unannounced focused inspection carried out on 1 May 2018 in response to concerns that were reported to us, and to check whether the practice had carried out their plan to address requirements relating to the breach in regulations we identified in the previous inspection on 24 April 2017.

Our key findings were as follows:

- Significant events were not consistently identified or acted upon to improve patient safety.
- A GP partner was using NHS practice resources including NHS appointments, staffing, premises and equipment for a private patients cosmetic and slimming clinic business.
- Do not attempt resuscitation arrangements (DNAR) for patients in a nursing and care home were not provided with their consent or consent of the relevant person.
- There was an unsatisfactory working culture including staff withholding, changing or being worried about providing us with information and there were divides between staff teams at all levels, including the leadership team.

Whilst previous concerns had been remedied, new issues of concern were identified at this inspection.

There were areas of practice where the provider must make improvements:

- Ensure that care and treatment of patients is only provided with the consent of the relevant person.
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Population group ratings

Older people	**Not sufficient evidence to rate**
People with long-term conditions	**Not sufficient evidence to rate**
Families, children and young people	**Not sufficient evidence to rate**
Working age people (including those recently retired and students)	**Not sufficient evidence to rate**
People whose circumstances may make them vulnerable	**Not sufficient evidence to rate**
People experiencing poor mental health (including people with dementia)	**Not sufficient evidence to rate**

Our inspection team

Our inspection team was led by:

The CQC inspection team consisted of a lead inspector, a GP specialist adviser, two further inspectors, and a pharmacist specialist.

Background to Essex Lodge

The Essex Lodge practice is a GP practice situated within NHS Newham Clinical Commissioning Group (CCG). The practice provides services to approximately 11,200 patients under a Personal Medical Services (PMS) contract. The practice had recently inherited approximately 3,000 patients and a staff team from a nearby practice that closed down.

The practice provides a full range of enhanced services including childhood immunisations, avoiding unplanned admissions, IUCD (also known as the "coil") fitting, extended hours, and minor surgery including excisions and joint injections. It is registered with the Care Quality Commission to carry on the regulated activities of Maternity and midwifery services, Family planning services, Treatment of disease, disorder or injury, Surgical procedures, and Diagnostic and screening procedures.

The staff team at the practice includes two male GP partners, three salaried GPs, two regular locum GPs, three practice nurses, a health care assistant, a counsellor, a practice manager and deputy practice manager, and a team of reception, secretarial and administrative staff. The practice teaches medical students and trains GP registrars. Extension works to the premises are underway to provide space for additional resources such as consulting rooms, a larger waiting room and a quiet room for patients. The building currently has two floors with lift access to the first floor.

The practice is open weekdays from 8.00am to 7.00pm (except on Thursday when it closes at 6.00pm), and on Saturday from 8.00am to 12.00pm. Core appointments times are from 8.30am to 1.30pm and 4.00pm to 6.00pm every weekday except Thursday when afternoon surgery runs from 2.30pm to 5.00pm. Extended hours appointments are offered every weekday from 8.00am to 8.30am and on Saturday from 8.00am to 10.30am. The practice does not close its doors or telephone lines for lunch and provides home visits and telephone consultations for patients. Pre-bookable appointments are available including online in advance. Urgent appointments are also available for people that need them. Patients telephoning for an out of hour's appointment are transferred to the Newham cooperative deputising service.

The Information published by Public Health England rates the level of deprivation within the practice

population area as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. 66% of people in the practice area are from Black and Minority Ethnic (BME) groups.

Not sufficient evidence to rate

Are services safe?

Lessons learned and improvements made

There was variable learning and improvement when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses but leaders and managers did not always take necessary action to support them when they did so.

Significant events identified were not consistently acted upon to improve safety in the practice. However, we also found examples where systems had been implemented for reviewing and investigating when things went wrong and the practice learned and shared lessons, and took action to improve safety.

Please refer to the Evidence Tables for further information.

Not sufficient evidence to rate

Are services effective?

At our previous inspection on 24 April 2017, we rated the practice as requires improvement for providing effective services because it did not have a full and clear picture about staff training. There were also gaps in staff training such as infection prevention and control, information governance, fire safety and basic life support.

These arrangements had improved when we undertook a follow up inspection on 1 May 2018; however, new concerns were identified relating to patients who lived in a local nursing and care home. The concerns were around consent to care and treatment.

Effective staffing

Arrangements had been implemented to address staff overdue training which was completed including for infection prevention and control, information governance, fire safety and basic life support and a training matrix was in place to ensure staff training would remain current.

Consent to care and treatment

The practice did not obtain consent to care and treatment in line with legislation and guidance.

- Records held at a local care home showed that a high proportion of more than 80% of 55 patients at a local nursing home that Essex Lodge GPs provided a service to have been signed off by GPs as "DNAR", which means do not attempt to resuscitate. There were situations DNAR arrangements were appropriate; however, documentation showed GPs had not supported patients to make decisions or assessed and recorded patient's mental capacity appropriately. Two patient's DNAR forms were amended by GPs after concerns were raised but there was no date recorded to indicate when the amendments were made; and it therefore appeared amendments were included at the time the forms were originally completed, but this was not the case. The DNAR process is a formalised process with legal implications under the Mental Capacity Act 2005 which has profound ramifications for patients if not undertaken correctly. The DNAR process had not been monitored and there was no evidence the practice had reviewed it for all individual patients as needed. The lead partner GP told us DNAR discussions are held with the patient and family/next of kin, with ward staff and GPs and with Macmillan nurses; and after these discussions once a decision has been agreed for DNAR the form is then completed and signed by GPs. However, this process was not reflected on DNAR forms that had been signed off by GPs. After our inspection the practice told us it recognised DNAR errors were made and sent us evidence it had produced a DNAR policy and this issue was being dealt with as significant event.

Please refer to the Evidence Tables for further information.

Not sufficient evidence to rate

Are services well-led?

Leadership capacity and capability

Leaders had the skills to deliver high-quality, sustainable care but did not consistently do so.

- Leaders were knowledgeable about issues relating to the quality of services but did not recognise or address concerns that affected patient's care that were either brought to their attention or should have been apparent through day to day processes. For example, there was a dysfunctional working culture where significant events were identified but not acted upon.
- Staff told us there was routinely no leadership or management cover after 3 to 4pm in the afternoon, including on the day prior to our inspection when the practice computer system had gone down. After our inspection, the provider told us there was a rota for management cover on Monday to Friday 8am to 7pm since the practice completed recruitment of the management team; however, the most recent member of the management team first working day was the day of our inspection 1 May 2018. This indicated the 8am to 7pm rota cover arrangement was new and provided no evidence that management capacity had been provided appropriately. Management staff also told us there was a gap of management cover on two days which they were aware of, and confirmed the computer system had gone down the day prior to our inspection which was dealt with by reception staff.

Culture

There was an unsatisfactory and unhelpful working culture with evidence of inappropriate priorities and divided teams.

- The practice NHS resources were being used for one of the GP partner's private businesses, including NHS patient's appointment slots, premises, equipment and staffing. The lead GP Partner and management staff told us private patients were not seen during NHS sessions but the practice computer system evidenced NHS slots were used for private patient consultations and staff also told us this was the case. This indicated leaders either consciously denied or were out of touch with what is happening during day-to-day services and serving NHS patients may not have been the providers' first priority.
- There was evidence of staff withholding, changing or being worried about providing us with information. For example, at the outset of our inspection the lead partner GP told us all private appointments are undertaken off-site, but this was not the case. After our inspection managers and the lead partner GP told us private patients are seen on site but disputed this was during NHS sessions; however, evidence included on the evidence table appended to this report shows private patients were seen during NHS sessions.
- Some staff we interviewed asked us to please not tell a lead GP what they were sharing with us. Other worries or concerns expressed by staff when answering our questions were what might happen next including being picked on, a pattern of longstanding staff being sacked unexpectedly by the lead GP and when they (existing staff) raised concerns the leadership and management staff being dismissive or making counter allegations against them, some staff perceived there was an agenda to "get rid" of longer serving staff that had raised concerns within the practice. After our inspection the practice told us there had been some difficult staffing issues that required managing and there was currently no significant evidence of staff being unhappy.
- There was a pattern of high staff turnover with legal processes entailed for HR and other issues that had been escalated and not resolved or managed within the in-house team. Some existing staff were happy working at the practice but others were not and there was evidence of divides within the staff team at all levels. Leaders and managers denied and disputed staffs perceptions and experiences when asked for an opinion which indicated a lack of receptivity and appropriate staff engagement. A lead GP partner and management staff told us they thought these issues were due to aspects such as staff being disgruntled, family or underperformance issues, language barriers or clashes of character, and that they were acting to manage the recent changes of a new staff team. However, there was no evidence of a plan for managing team changes to consider equalities and teamwork. Significant events and complaints some staff were aware of and in some cases had escalated formally were ignored, this indicated systems to ensure and improve quality and safety were not operating effectively. Staff told us some patients had complained private patients were prioritised over NHS patients, but there was no evidence of this on the practice complaints log.
- Some staff said they were not treated equally such as a lack of protected time to undertake training with one

Not sufficient evidence to rate

Are services well-led?

group of staff being permitted protected time for learning at work and another group not being afforded this opportunity. After our inspection management staff told us they were working within the equality and diversity policy and they held staff meetings to promote joint working. Management staff said views were sought from some staff on several occasions, but not all staff were questioned.

Governance arrangements

Systems to support good governance were not always effective.

- There were processes for providing staff with the development they needed. This included appraisal and career development conversations and staff were supported to meet the requirements of professional revalidation where necessary.
- Staff were not able to access policies via the practice IT system. Management staff told us this was due to the installation of new PCs at the newly extended site, that they have remedied this issue and hard copies of all the policies and procedures are available for all staff to access.
- Staff, ex-staff and patients information was shared on a WhatsApp group. (WhatsApp is a free to download messenger app for smartphones that uses the internet to send messages, images, audio or video). After our inspection the practice told us no harm had come to a patient, and that this incident would be treated as a significant event and had been discussed at a clinical meeting and would be discussed at monthly staff meetings. The practice also said it would provide GDPR training to staff, and that WhatsApp pseudo anonymised data and the WhatsApp group had been deleted. (GDPR is the General Data Protection Regulation which is a regulation in EU law on data protection and privacy for all individuals within the European Union and the European Economic Area. It also addresses the export of personal data outside the EU and EEA).
- Staff at all levels told us only one GP partner made the decisions and they knew they should only report to that GP partner. After our inspection the practice told us this was not the case as there are clinical and non-clinical teams with responsibilities and decision-making capabilities set out and meetings held accordingly; and that the two partners each have different duties and decision-making responsibilities.
- The practice held regular meetings such as management, clinical, nurses and healthcare assistants, and practice manager with reception staff meetings.

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance but they were not consistently implemented.

- Significant event issues that threatened the delivery of safe and effective care were not identified or adequately managed.

Please refer to the Evidence Tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is 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:** The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Significant events management including occasions where patient's attended accident and emergency, or were admitted to hospital, or died. **This was in breach of regulation 12(1) 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 were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided or mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The provider was not aware of activities being undertaken that were utilising its own resources such as staffing, premises, appointment time and equipment. • To assess and improve the quality of DNAR process.There were no systems or processes that

This section is primarily information for the provider

Requirement notices

enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Health checks undertaken inappropriately or marked as undertaken but not done.
- Patient's information shared on a staff WhatsApp group.

This was in breach of regulation 17(1) 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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had failed to act in accordance with the Mental Capacity Act 2005 when providing care and treatment to service users who are 16 or over and unable to give consent because they lack capacity to do so. In particular: • Do not attempt resuscitation (DNAR) process forpatients in a care home. **This was in breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**