Nuffield House Doctors Surgery

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Good
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 Nuffield House Doctors Surgery on 27th October 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the 27th October 2016 inspection can be found by selecting the 'all reports' link for Nuffield House Doctors Surgery on our website at www.cqc.org.uk.

This inspection was an announced inspection carried out over two days: on 8th August 2017 and 5th September 2017. This was to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 27th October 2016. This report covers our findings in relation to those requirements and also additional concerns identified at our most recent inspection. We found that sufficient improvement had not been made.

Overall the practice is rated inadequate.

- Governance at the practice was inadequate. There had been significant changes within the partnership over the last year, which had affected leadership. However, there were some improvements made during the course of our inspection.
- The practice's action plan that was submitted in response to the October 2016 inspection remained outstanding.
- There were systems to review most patients taking high risk medicines although the monitoring of patients taking lithium was not effective. Only one out of six patients taking this medicine had received appropriate monitoring before a repeat prescription was issued.
- The management of patient safety and medicine alerts had improved, as had the system for recording, learning and actioning change as a result of significant events.
- There was a weekly ward round at a local care home by the GP medicine lead at the practice.
- An additional salaried GP had been appointed whose responsibility was to coordinate and manage the care of the practice's frail patients.

Summary of findings

- The infection control audit was incomplete. The infection control policy was dated 2013 and referred to staff who had left the practice. Infection control training was scheduled to take place for all staff members in the weeks following our inspection, as was a further infection control audit.
- The practice had completed a health and safety and fire risk assessment although there was no Control of Substances Hazardous to Health (COSHH) risk assessment.
- Chaperones were now DBS checked which sought to ensure their suitability for the role.
- The practice was now recording immunisation status. They were also recording registration with professional bodies and medical indemnity insurance, although this was not recorded for all members of the clinical team.
- There continued to be a low number of carers identified. Systems to support carers were limited.
- Data showed patient outcomes in respect of interactions with GPs had improved and these were now comparable to the local and national average. However, patient satisfaction was below local and national average in relation to how easy it was for patients to get through on the phone.
- QOF performance continued to be in line with or better than local and national averages. There had been improvements in relation to low performance for one diabetes indicator, although there continued to be high exception rates in relation to a mental health indicator.
- Policies had been updated in respect of safeguarding children and safeguarding adults.
- Non-clinical staff were unclear as to who in the practice was the lead for safeguarding and had not received safeguarding training. Clinical staff had received some safeguarding training, but not to the level required for their role.
- Clinical audits were being completed and were used to improve performance where identified
- There was a lack of systems to ensure the competency of staff. There were gaps across all training. The system to record and review training was inconsistent.
- There were no appraisals completed for non-clinical staff.
- Prescription stationery was stored securely although there were no systems to track its location during the course of the day.
- Recruitment checks were not consistent.
- Evidence of conduct in previous employment and training was not requested when locum GPs were engaged to work at the practice.
- There had been no formal learning disabilities checks in the last year, although a template had been created and a clinical lead for learning disabilities appointed.

The areas where the provider must make improvements are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider should make improvements are:

- Improve the identification and systems to support patients who are carers.
- Improve patient satisfaction in relation to getting through to the practice by phone.

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.

- There were not effective systems in place to protect children and vulnerable adults from abuse as staff had not received appropriate training and were not aware of the lead for safeguarding.
- Not all patients prescribed lithium were being monitored before a repeat prescription was authorised.
- The infection control audit was scheduled to take place at the end of the year, as the previous infection control audit was incomplete.
- The infection control policy was out of date. Infection control training had been booked to take place in September 2017.
- The practice had completed a health and safety and fire risk assessment, although not a COSHH risk assessment.
- Recruitment checks were not consistent.
- The system for reporting and learning from significant events had improved. There was a lead clinician for oversight of significant events. Lessons were shared to make sure action was taken to continually review safety in the practice.
- Improvements were made to the system for managing patient safety and medicine alerts. Relevant patients were identified and reviewed as appropriate.
- Chaperones were DBS checked.
- The practice recorded immunisation status. They were also recording registration with professional bodies and medical indemnity insurance, although this was not recorded for all members of the clinical team.
- Prescription stationery was held securely although this was not tracked as to its location around the practice.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- At our 2016 inspection, high exception reporting had been identified in relation to one mental health indicator. Unverified data indicated minor improvement, although this was still higher than expected.
- There had been no formal learning disabilities checks in the last year, although a template had been created and a clinical lead for learning disabilities appointed.

Summary of findings

- There was a lack of systems to ensure appropriate appraisal of non-clinical staff.
- At our 2016 inspection, we identified that the practice was lower than CCG and national average for one diabetes indicator. Unpublished data for 2016/2017 demonstrated improvement.
- The lead nurse for diabetes had left over a year ago, although one of the nurses was now completing their specialist training.
- The system in place to record and monitor staff training had not been completed. Clinical staff had not received training relevant to their roles.
- Clinical audits were being completed and were used to improve performance when this was identified as required.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data showed patient outcomes relating to interactions with GPs had improved and these were now comparable to the local and national average.
- House-bound patients were due to receive additional support with their health and social care requirements. From October, requests for home visits would be responded to by a designated team comprising of a GP, advanced nurse practitioner and social worker.
- The practice continued to identify a low number of patients who were carers. There was nothing in place to support patients who were carers.
- Reception staff were aware of patients who may be visually impaired or experiencing hearing difficulties and would provide them with appropriate support when their appointment was being called.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this to make improvements to the practice population, for example, there was a weekly ward round at a local care home by the GP medical lead at the practice.
- An additional salaried GP had been appointed whose responsibility was to coordinate and manage the care of the practice's frail patients.
- Patients raised some concern about getting through to the practice by phone. The practice was publicising on-line services.

Summary of findings

- Information about how to complain was available and evidence from seven examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Inadequate

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

- Some actions detailed in the action plan as a result of the October 2016 inspection remained outstanding.
- Governance at the practice was not effective. There had been significant changes within the partnership over the last year, which had affected leadership.
- Areas for improvement had not been identified or actioned by the practice. Whilst many areas of risk were highlighted by inspectors in 2016, these were either still outstanding in 2017 or being rectified during the course of the inspection.
- The practice had not identified and mitigated some risks to patients and staff.
- Policies and procedures were in the process of being updated.
- The provider was aware of the requirements of the duty of candour. In seven examples we reviewed we saw evidence the practice complied with these requirements.
- The practice proactively sought feedback from patients and we saw examples where feedback had been acted on. The practice involved the patient participation group in decisions.
- The practice engaged with local practices and stakeholders with a view to improving performance.

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 practice is rated as inadequate for providing safe, effective and well-led services and good for providing caring and responsive services. The evidence which led to these ratings applies to all population groups, including this one.

- There was an identified GP at the practice who managed the care of all older patients who were on the list of frail patients.
- Staff had not received up to date safeguarding vulnerable adults training. A safeguarding vulnerable adults' policy was written during the course of our inspection.
- 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. A designated team comprising of a GP, advanced nurse practitioner and social worker responded to home visits.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. The practice was improving the way that they shared information with the local hospice.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The practice is rated as inadequate for providing safe, effective and well-led services and good for providing caring and responsive services. The evidence which led to these ratings applies to all population groups, including this one.

- The practice were improving the way that they shared information, commencing a regular monthly multi-disciplinary meeting with social workers, representatives from the local hospice and district nurses from October 2017.
- The practice nurse took the lead in reviews and management of patients with long term conditions. They were undertaking training in relation to the management of diabetic care.
- At our 2016 inspection, we identified that the practice were lower than CCG and national average for one diabetes indicator. Unpublished data for 2016/2017 demonstrated improvement.

Summary of findings

- There was a weekly ward round at a local care home by the GP medical lead and a pharmacist from the CCG.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The practice is rated as inadequate for providing safe, effective and well-led services and good for providing caring and responsive services. The evidence which led to these ratings applies to all population groups, including this one.

- Staff had not received up to date training on safeguarding children and were unsure who to go to if they had concerns.
- A midwife held a weekly clinic at the practice by appointment.
- Immunisation rates were in line with CCG and national averages for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The health visitor attended weekly meetings at the practice.

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 practice is rated as inadequate for providing safe, effective and well-led services and good for providing caring and responsive services. The evidence which led to these ratings applies to all population groups, including this one.

- Appointments could be booked with a GP, nurse or HCA in the evenings or on the weekend at the local 'hub'. Services were provided through a number of local health centres in Harlow, Epping Forest and Uttlesford.
- The practice offered online appointment booking and prescription requests.
- The percentage of women aged 25-64 who had a cervical screening test in the past 5 years was in line with the CCG and national average.
- 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.

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 practice is rated as

Summary of findings

inadequate for providing safe, effective and well-led services and good for providing caring and responsive services. The evidence which led to these ratings applies to all population groups, including this one.

- The number of carers on their practice register was low. The practice had identified 103 patients as carers (0.7% of the practice list). There were no systems to support carers.
- There had been no formal learning disabilities checks in the last year, although a template had been created and a clinical lead for learning disabilities appointed.
- The practice had begun to do a weekly ward round at a local care home to proactively meet the needs of patients who lived there. This was attended by the GP medicines lead and a pharmacist from the CCG medicines management team.
- The practice was to introduce a designated clinical and social team to respond to requests for home visits.
- The practice held a register of patients living in vulnerable circumstances including homeless people, temporary patients living in a women's refuge and those with a learning disability.
- If patients required a longer appointment due to complex needs or multiple medical conditions this was available.
- The practice was improving their systems of sharing information with other healthcare professionals.

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 practice is rated as inadequate for providing safe, effective and well-led services and good for providing caring and responsive services. The evidence which led to these ratings applies to all population groups, including this one.

- Appropriate monitoring was not taking place for patients with poor mental health who were prescribed a certain medicine.
- At our 2016 inspection, high exception reporting had been identified in relation to one mental health indicator. Unpublished data only indicated minor improvement.
- The practice worked closely with mental health professionals to deliver coordinated care in the community.
- Longer appointments were available for patients experiencing poor mental health.
- The practice sign-posted patients to local voluntary support services.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with local and national averages. 206 survey forms were distributed and 103 were returned. This was a completion rate of 39%. Results were mixed, being line with averages in relation to interactions with the GPs and nurses although lower than average with regards to getting through on the phone. For example:

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%
- 78% 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 the national average of 82%.
- 50% of patients said they could get through easily to the practice by phone compared to the CCG average of 62% and the national average of 71%.
- 88% 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%.
- 65% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 84% 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%.

We spoke with six patients including two members of the patient participation group (PPG). All patients that we spoke with were complimentary about the care that they received from all staff at the practice, although they told us there was some delay when trying to telephone the practice in the morning.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Improve the identification and systems to support patients who are carers.
- Improve patient satisfaction in relation to getting through to the practice by phone.

Nuffield House Doctors Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP specialist advisor and a nurse specialist advisor.

Background to Nuffield House Doctors Surgery

Nuffield House Doctors Surgery is situated in Harlow, Essex in premises shared with health visitors and speech and language therapists. There are parking bays for patients who are disabled or with limited mobility; otherwise there is a public car park available close by.

The list size of the practice is approximately 13,250. There have been recent changes to the partnership and the practice is in the process of updating its registration with the CQC. Since our previous inspection, three partners have retired and been replaced. There are now five male GP partners and one female GP partner. A male salaried GP and a female advanced nurse practitioner have also been recruited. There are a number of other staff carrying out administrative and clerical duties, led by a full-time practice manager.

This practice is a teaching and training practice and has medical students and GP registrars in their final stage of training. GP registrars are fully qualified doctors and will have had at least two years of post-graduate experience. Medical students may observe patient consultations and examinations with the patient's consent.

The practice is open between 8am and 6.30pm on Mondays to Fridays and is closed at the weekends. GP appointments times are from 9am to 12 noon and 3pm to 5.30pm. In addition to this, GPs are available for patients needing an urgent appointment or requiring home visits. Practice nurse appointments are from 9.30am to 6pm on Mondays; 8.40pm to 6pm Tuesday to Thursday. There are separate sessions for minor surgery and contraceptive implants.

When the practice is closed patients are advised to call 111 if they require medical assistance and it cannot wait until the surgery reopens. There is also a pre bookable weekend service, via Stellar Healthcare, across West Essex which is based at seven different locations. Appointments are made through the practice.

There are slightly higher than local and national average levels of income deprivation affecting children and older people at this practice. The numbers of older people, babies, children and working age people registered at the practice was in line with the national average.

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, following concerns identified at a previous inspection in 2016. This inspection was to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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 8 August 2017 and 5 September 2017.

During our visit we:

- Spoke with a range of staff including GPs, nursing and administration staff.
- Spoke with patients.
- Reviewed documents including policies, procedures, training records and a sample of the treatment records of patients.

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

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

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

What we found at our inspection in October 2016

Although significant events were being recorded, it was unclear what action took place to learn from the event. We found no evidence that MHRA (Medicines and Healthcare Products Agency) alerts were being actioned to ensure that patients who may have been subject to the alert were safe and that risks were mitigated. No infection control audit had been completed within the last year and appropriate training had not taken place. There was no system to ensure that staff received immunisations relevant to their role, that clinical staff remained registered with their professional bodies or that medical indemnity insurance was in place. There was no evidence that administrative staff had received basic life support training. The business continuity plan had not been reviewed for several years.

The practice was rated as requires improvement for providing safe services. Sufficient improvements had not been made at our most recent inspection.

What we found at our inspection in August and September 2017

Safe track record and learning.

- Improvements had been made to the recording and learning from significant events during the course of our inspection.
- There was a lead clinician appointed to manage significant events, and staff who were involved in the significant event completed relevant forms. These were passed to the lead clinician for initial consideration and action. Significant event meetings were now taking place every three months. These were attended by clinical and non-clinical staff as appropriate. A member of administrative staff had been appointed to take minutes so that learning and action could be effectively monitored and reviewed. The management of significant events was underpinned by a significant event policy.
- We looked at the minutes of the last significant event meeting. These evidenced a discussion into what went wrong, whether action was taken to contact the patient (as relevant) and the learning outcomes.
- The practice received patient safety and medicines alerts from the MHRA (Medicines and Healthcare Products Regulatory Agency). These were added to a spreadsheet which was intended to detail what action had been taken to effectively manage the alert. However, we found that this was incomplete as three alerts in June 2017 had not been noted as received.
- The practice had completed a search to identify patients at risk due to a MHRA alert raised in April 2017. This related to the use of an epilepsy medicine. However, no further action was taken to contact the patients to mitigate the risk. During the course of our inspection, we were shown evidence to confirm that relevant patients had since been contacted and invited for a review.
- Systems for managing MHRA alerts were improved during the course of our inspection: the medicines management lead was now responsible for identifying patients who may be at risk as a result of the alert, and this information was being passed to relevant patients' GPs so that the patient could be contacted and reviewed accordingly.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safeguarded from abuse.

- The safeguarding children policy had been updated in July 2017. A safeguarding vulnerable adults' policy was drafted and available for staff to access by the time of our second inspection visit. Administrative staff had not received training on safeguarding children and vulnerable adults and did not know who the lead clinician was for safeguarding was.
- The practice was unclear as to what would constitute level two or three children's safeguarding training for clinicians. We reviewed the training matrix for GPs and nurses. This did not distinguish between safeguarding adults and safeguarding children training and a level two certificate was provided as evidence of a GPs' safeguarding training. The practice did not consistently request or receive information to confirm that locum GPs were trained to an appropriate safeguarding level. Clinical staff were not trained to a level appropriate to their role.
- Chaperones had now received a Disclosure and Barring Service (DBS) check and had received training. (DBS

The practice maintained appropriate standards of cleanliness and hygiene, although improvements were still needed:

Inadequate

Are services safe?

- The advanced nurse practitioner was the infection control lead. They were scheduled to complete their infection control training in the days following our second inspection visit, along with other clinical and administrative staff. Another session had been booked to take place later in the year for staff that were unable to attend.
- The infection control audit was not complete and did not contain any action plans to remedy issues found. This was commenced the day prior to our inspection. A further infection control audit was scheduled to take place in November 2017.
- The infection control policy was dated 2013 and referred to staff who had since left the practice.
- The legionella risk assessment advised that a further risk assessment was required this year. The practice was unaware of whether this had taken place.
- There was now a system in place to ensure that staff received appropriate immunisations relevant to their role.

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 the review of patients who were prescribed most high risk medicines. Whilst we found that there were, on the whole, effective systems in place to recall patients to have the required checks and blood tests, this was not the case for one medicine, lithium which is prescribed to patients with poor mental health. We looked at the six records of relevant patients and found that only one out of the six patients had received the requisite testing in the last three months. On further investigation, it became apparent that this was due to confusion in relation to current guidelines.
- 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 three personnel files and found appropriate recruitment checks were not consistently undertaken prior to employment. For example, we found that proof of identification was not present on one file and evidence of satisfactory conduct in previous employments in the form of references was not present on two files.

We also reviewed the information that the practice received when they engaged locum GPs. We looked at three files. Whilst we found that the practice consistently received information to confirm the locum GPs' indemnity status, identity, DBS and that the locum was registered with professional bodies, they did not receive or request references from previous employers.

The practice had begun to make checks to ensure that permanent clinical staff remained registered with their professional bodies and that medical indemnity insurance was in place, although this was not complete.

Monitoring risks to patients

- 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 conducted a health and safety and fire risk assessment. A fire drill had been completed in the year of our most recent inspection. However, there was no Control of Substances Hazardous to Health (COSHH) risk assessment. Staff did not to have health and safety training. This was identified at our previous inspection.
- There had been significant changes to the clinical team as GPs and nurses left and joined the practice. The practice was in the process of reviewing and developing the skills mix and sought to ensure that patients' needs were being met. Information was available at the reception desk which advised patients of these changes and of the role of the advanced nurse practitioner.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to respond to emergencies and major incidents, although clinical and non-clinical staff still had not received annual basic life support training:

Inadequate

Are services safe?

- 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.
- Emergency medicines were easily accessible to staff in a secure area of the practice. 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 had been update and now included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

What we found at our inspection in October 2016

Although the practice was not an outlier for any clinical targets for 2015/2016, there were areas where the performance was lower than local and/or national averages. This was in relation to one diabetes indicator and exception reporting for a mental health indicator. There was no evidence of clinical review or plans in place to reduce this exception reporting rate.

The system for monitoring the training of staff needed improving as this did not record the training that had taken place or was required.

The practice was rated as requires improvement for providing effective services. Sufficient improvements had not been made at our most recent inspection.

What we found at our inspection in August and September 2017

Effective Needs Assessment

Staff had access to guidelines from National Institute for Health and Care (NICE) and online resources.

The adherence to NICE guidelines was considered during audits, where improvements were identified and action implemented. However, we found examples where the practice was not adhering to guidelines, for example in relation to monitoring patients taking lithium.

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).

This practice was not an outlier for any QOF (or other national) clinical targets. However, data from 2015 to 2016 showed that the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 65% compared with the CCG average of 74% and the national average of 78%. Unpublished data extracted from the practice system on the day of inspection showed an improvement for 2016/2017 to 84%.

At our inspection of 2016, we found that the exception reporting rate for one mental health indicator was higher than average at 48%. Exception reporting is the means by which the practice can exclude patients from their data due to certain characteristics. Unpublished data extracted from the practice system on the day of inspection showed that whilst there had been minor reduction in exception reporting for this indicator, this remained high at 45%.

Other QOF indicators for 2015/16 were as follows:

- The percentage of patients on the register who had an asthma review in the preceding 12 months that included an assessment of asthma control using the 3 RCP) questions was 83% which was in line with the CCG average of 75% and England average of 76%. Exception reporting for this indicator was higher than average at 22% compared to the CCG average of 6% and England average of 8%. Unpublished data for 2016/17 showed that exception reporting remained high for this indicator at 22%.
- The percentage of patients with atrial fibrillation with a record of a risk assessment for blood clots and stroke was 82% which was in line with the CCG and England average of 87%. Exception reporting was in line with CCG and England averages.
- The percentage of patients with hypertension whose last blood pressure reading was within a given range was 81% compared the CCG average of 80% and England average of 83%. Exception reporting was in line with CCG and England averages.

There had been no formal learning disabilities checks in the last year, although a template had been created and a clinical lead for learning disabilities appointed.

There was evidence of quality improvement including clinical audit:

- There had been multiple two cycle clinical audits commenced in the last two years, where the improvements made were implemented and monitored. Single cycle audits were being completed where a need was identified. Audits considered the use of antibiotics, uptake of vaccinations, medicines used for patients with diabetes and contraceptives.
- Findings were shared during practice meetings and used by the practice to improve services, for example by providing more information to patients and encouraging better use of information systems.

Inadequate

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff did not always have had the skills, knowledge and experience to deliver effective care and treatment:

- There had been no appraisals for administrative staff, including the practice manager, in the last two years, although nurses had all received an annual appraisal.
- The learning needs of staff could not be ascertained as the training matrix was incomplete. Staff had not received safeguarding, health and safety or basic life support training. Infection control training had been scheduled to take place shortly after our inspection.
- The learning needs of nursing staff had been identified. As the lead nurse for diabetes had left the practice, another nurse was completing their certificate in diabetes care.

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.

The practice was improving the way that they shared information. At our first inspection visit, brief, twenty minute meetings were taking place on a weekly basis with GPs and nurses from the practice, the health visitor, district nurse and representatives from a local care home to discuss patients with complex health and social care needs. It had been acknowledged that this did not effectively meet the needs of the practice population and therefore, the practice were commencing a regular monthly multi-disciplinary meeting with social workers, representatives from the local hospice and district nurses. This was scheduled to take place from October 2017.

The practice had begun to do a weekly ward round at a local care home to proactively meet the needs of patients who lived there. This was attended by the GP medicines lead and a pharmacist from the CCG medicines management team.

In October 2017, the practice would be obtaining further resources to respond to all requests for home visits between the hours of 8am until 6.30pm. This was a designated team comprising of a GP, advanced nurse practitioner and social worker. The practice informed us that as they did up to 15 home visits per day, this would increase clinical capacity within the practice. In addition to this, it had been ascertained that as the practice had a number of patients on the frailty list, a salaried GP and healthcare assistant had been employed from September to co-ordinate and manage the care of these patients.

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.

- 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.
- Audits reviewed arrangements for obtaining consent, specifically in relation to patients who had contraceptive implants fitted.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Health promotion advice, blood pressure checks and smoking cessation advice were available from the practice nurse. Information was also available on the practice website.

The practice's uptake for patients aged 25-64 attending cervical screening within the relevant target period was 74%, which was comparable to the CCG average of 75% and the national average of 72%. Other indicators for cervical screening were in line with local and national averages. There were 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.

Inadequate

Are services effective?

(for example, treatment is effective)

Data for other national screening programmes such as bowel and breast cancer showed that the practice uptake was in line with the local and national average. For example, the uptake of screening for bowel cancer by eligible patients in the last 30 months was 52% for the practice, compared to 58% for the local and national average. The uptake of screening for breast cancer by eligible patients in the last 36 months was 70% for the practice, compared to the local average of 70% and the national average of 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example,

- The percentage of childhood 'five in one' Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza immunisation vaccinations given to under one year olds was 98% compared to the local average of 95% and the national average of 93%.
- The percentage of childhood Mumps, Measles and Rubella vaccination (MMR) given to under two year olds was 95% compared to the local average of 93% and the national average of 91%.
- The percentage of childhood Meningitis C vaccinations given to under five year olds was 96% compared to the local average of 96% and the national average of 83%.

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.

Good

Are services caring?

Our findings

What we found at our inspection in October 2016

The practice was rated as good for providing caring services, although results from the national GP patient survey, published in July 2016, showed patients experience of the service was mixed. The practice was lower than average for its satisfaction scores on consultations with GPs. Further, the practice had not been proactive at identifying carers on their practice list. We said that the practice should consider ways to improve patient satisfaction as identified from the GP survey.

What we found at our inspection in August and September 2017

Kindness, dignity, respect and compassion

During our inspection we observed that 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; conversations taking place in these rooms could not 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 treated by a clinician of the same sex.

We spoke with six patients including two members of the patient participation group (PPG). All patients that we spoke with were complimentary about the care that they received from all staff at the practice.

Results from the national GP patient survey, published in July 2017, showed patients experience on consultations with GPs had improved and were now in line with local and national averages. Feedback in relation to patient experience with the nurse continued to be in line with CCG and national averages. For example:

- 87% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%. This was better than the 2016 results of 79%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 86%. This was better than the 2016 results of 77%.
- 92% said the last nurse they saw or spoke to was good at listening them compared to the CCG and national average of 91%.
- 95% had confidence and trust in the last nurse they saw or spoke to compared to the CCG and national average of 97%.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey, published in July 2017, showed patients responses to questions about their involvement in planning and making decisions about their care and treatment with a GP had improved and were now in line with local and national averages. Feedback in relation to patient experience with the nurse continued to be in line with CCG and national averages. For example:

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%. This was better than the 2016 results of 74%.
- 78% 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 the national average of 82%. This was better than the 2016 results of 70%.
- 90% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG and national average of 90%.
- 87% of patients said the least nurse they saw or spoke with was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

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. The practice website could be translated into a number of different languages.
- Reception staff were aware of patients who may be visually impaired or experiencing hearing difficulties, and would provide them with appropriate support when their appointment was being called.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

The practice's computer system alerted GPs if a patient was also a carer. At our previous inspection in 2016, we ascertained that the practice had identified a low number of patients who were carers: 100 patients (0.7% of the practice list). At our 2017 inspection, we found that the practice had identified three more patients who were carers. The practice did not offer a routine health check for carers and we were informed that there were no other services that were offered to carers.

From October 2017, there were going to be additional services to house-bound patients with their health and social care requirements as requests for home visits between the hours of 8am until 6.30pm would be responded to by a designated team comprising of a GP, advanced nurse practitioner and social worker.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

What we found at our inspection in October 2016

The practice was rated as good for providing responsive services, although results from the national GP patient survey, published in July 2016, showed patients experience of the service was lower than local and national averages.

What we found at our inspection in August and September 2017

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- Appointments could be made to have blood tests at the practice Monday to Thursday.
- The practice had implemented telephone triage appointments system to ensure that patients who needed to be seen on the same day were given priority.
- Longer appointments were available for those patients that required them.
- From October 2017 all requests for home visits between the hours of 8am until 6.30pm would be responded to by a designated team comprising of a GP, advanced nurse practitioner and social worker.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There was a toilet with a wide access door, which had baby changing facilities.
- The practice was wheelchair accessible.
- All consultation rooms were located on the ground floor.
- Appointments could be made with a GP, nurse or HCA in the evenings or on the weekend at the local 'hub'. Services were provided through a number of local health centres in Harlow, Epping Forest,and Uttlesford.

The practice had a triage system to assess:

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

Access to the service

The practice was open between 8am and 6.30pm on Mondays to Fridays and was closed at the weekends. GP appointments times were from 9am to 12 noon and 3pm to 5.30pm. In addition to this, GPs had daily slots for emergency patients. Practice nurse appointments were from 9.30am to 6pm on Mondays; 8.40pm to 6pm Tuesday to Thursday. There were separate sessions for minor surgery and contraceptive implants. There was also a pre-bookable weekend and evening service across West Essex which was based at seven hub sites. Appointments were made through the practice.

Results from the national GP patient survey, published in July 2017, showed that patients continued to have some difficulty accessing the practice by telephone:

- 2016 data showed that 61% of patients said they could get through easily to the practice by phone compared to the CCG average of 64% and the national average of 73%. 2017 data showed that 50% of patients said they could get through easily to the practice by phone compared to the CCG average of 62% and the national average of 71%.

During our inspection, patients told us that there was some delay when trying to telephone the practice in the morning.

Although the practice was unaware of the recent GP survey results, they told us that they had made changes to the triage system which involved the receptionists asking patients for a brief description of the reason for their visit which was then used to ascertain the most suitable clinician available. We were informed that this had meant that phone lines were now busier. This was raised as an area for improvement at the last inspection. Despite this, no action plans have been put in place to improve performance. However, we noted that the practice was taking steps to promote the online booking service on the practice website and in the waiting areas.

Other results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 83% of patients were satisfied with the practice's opening hours compared with the CCG average of 73% and the national average of 76%.
- 79% of patients said their last appointment was convenient compared with the CCG average of 84% and the national average of 84%.
- 65% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 68% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 54% and the national average of 58%.
- 60% of patients usually wait 15 minutes or less after their appointment time to be seen compared to the local average of 59% and national average of 64%.
- 84% of patients would recommend the practice to someone new to the area compared to a local average of 75% and national average of 77%.

There was a four week wait for a routine appointment with a GP. On the day of our inspection, however, patients told us that they were able to make an appointment when they needed one. 2017 data from the GP patient survey accorded with this view, as feedback was in line local and national averages:

- 79% of patients were able to get an appointment to see or speak to someone last time they tried compared to the local and national average of 84%.

There had been a number of changes to the GPs and nurses at the practice. However, in addition to replacing outgoing staff, the practice had recently recruited an additional salaried GP whose responsibility was to coordinate and manage the care of the practice's frail patients. Further, receptionists were to receive training in managing scanned documents as it had been identified that this was taking up a significant proportion of GPs clinical time. Finally, it was anticipated that the appointment of a designated clinical team to respond to requests for home visits would allow clinicians to dedicate more time to seeing patients.

Listening and learning from concerns and complaints

The practice had an effective system for handling complaints and concerns. These were gathered from a variety of sources aside from formal written complaints. This included comment cards received and verbal matters raised at reception.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- Patients that we spoke with were confident in raising complaints, and staff knew how to manage these.

We looked at seven complaints received in the last 12 months and found that sufficient care and analysis was given to each complaint. These were responded to by the most appropriate person at the practice, depending on whether the complaint was administrative or clinical in nature. Where appropriate, complaints were managed in accordance with the significant event policy and we saw evidence that the complainant was advised of the outcome of the significant event learning and analysis.

Are services well-led?

Inadequate

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

Our findings

What we found at our inspection in October 2016

We found that improvements needed to be made to ensure that risks to patients were assessed and well managed. Some policies and procedures were out of date and required a review. The system for receiving and acting upon safety incidents was not effective.

The practice was rated as requires improvement for providing well-led services. Sufficient improvements had not been made at our most recent inspection.

What we found at our inspection in August and September 2017

Vision and strategy

The practice was experiencing issues balancing increasing demand with embedding and inducting new GP partners and staff. Three GP partners joined the practice at the beginning of the year, together with a salaried GP and an advanced nurse practitioner. An additional salaried GP was recruited in September 2017. During the course of our inspection, it was apparent that whilst the implementation of an effective vision and strategy had begun, this was yet to be effective. Whilst lead roles and responsibilities were assigned either prior to or during our inspection, these were still taking shape as new members of the team were acquainted with their roles.

The practice had not been proactive at identifying and actioning areas of concern that had been identified in our 2016 inspection. Improvements were being made during the course of our inspection in immediate response to our inspection visit, rather than already being effectively managed. Inspectors found continued and additional areas of risk.

Governance arrangements

Whilst we saw evidence to demonstrate that the governance framework at the practice was being developed, immediate improvements were required to ensure the delivery of good quality care.

The practice did not have effective systems to continually review, manage and mitigate risks to patients: risks that had been identified at our 2016 inspection had not yet been mitigated and the practice had not completed its own action plan. At our recent inspection, the practice were only beginning to take action in response to issues identified in 2016, and further risks were identified by inspectors that the practice were not aware of.

- There was limited improvement in administrative systems. The action plan submitted to us by the practice remained incomplete. Governance processes were not effective in identifying or some risks to patients and staff and therefore, these had not been mitigated.
- Improvements were being made to the system for managing significant events although these improvements were implemented during the course of our inspection. Significant event meetings were taking place in accordance with the practice's timetable and there was a member of administrative staff appointed to take meeting minutes. When we reviewed the minutes, these evidenced shared learning and actions. On reviewing the complaints, it was clear that these were being handled as significant events as appropriate.
- Policies and procedures were in the process of being updated. During the course of inspection, a safeguarding vulnerable adults' policy had been written and infection control training scheduled. An infection control audit had been commissioned to take place in the weeks following our inspection. The business continuity plan had been updated.
- Many administrative issues remained outstanding from our inspection of October 2016: the system to monitor staff training continued to be disordered, the training matrix was being updated during the course of our inspection and there was a lack of understanding of training requirements. Although the practice had purchased a new training package, this was yet to be used effectively.Staff were unclear about infection control principles and safeguarding vulnerable adults and children. They did not know who to go to if they had concerns about a vulnerable patient.

Leadership and culture

There was yet to be decisive leadership at the practice, although this was evolving as new members of the clinical team took over designated areas of responsibility. The partnership consisted of six partners although a lead partner was yet to be identified.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements

Are services well-led?

Inadequate

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

that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. From the seven documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology. Where complaints indicated concerns about safety, these were managed in accordance with the significant event policy.
- The practice kept written records of verbal interactions as well as written correspondence.
- Complaints were taken from a variety of sources. When comment cards had been received and these indicated dissatisfaction, these were followed-up in accordance with the provider's complaints policy.

The partners and administrative team worked together with the aim of delivering efficient patient care, but there was minimal time afforded to management, developing effective policies and procedures and training. At our first inspection visit, we had concerns about how this was impacting on patient safety and effectiveness, but at our second inspection visit, these concerns were mitigated as we saw that the partners had implemented a strategy which involved working with other practices and stakeholders to make improvements; positive steps were now being taken to manage clinicians' time. This included utilising additional resources to respond to home visits and the needs of frail patients, and training the administrative team to effectively scan documents. It was anticipated that these measures would afford partners with the required time to lead the practice.

- Clinical meetings occurred every Monday morning, which included the GPs, practice manager, data manager, practice nurse, advanced nurse practitioner and other professionals in the community. This was for twenty minutes a week. Some members of the clinical team were often unable to attend these due to work pressures. These meetings were not appropriately minuted, and brief, indecipherable notes of these were made in general notepads. There was no agenda.
- There was a weekly practice meeting which alternated between Tuesdays and Wednesdays to ensure staff working different hours could attend. These included the GPs, practice manager, data manager and clinical staff. These were now being attended by a member of the administrative team who would take minutes.
- From October 2017, the practice was holding a monthly multi-disciplinary meeting with social workers, representatives from the local hospice, district nurses and GPs from the practice.
- The practice had started conducting a weekly ward-round at a local care home. These visits were undertaken by the clinical lead for medicines and a pharmacist from the medicines management team.
- Non-clinical staff had not received an appraisal in over a year and their training needs had not been identified and acted upon.

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

The practice kept patients updated on changes to clinical staff at the practice, by way of information on the practice website and leaflets in the waiting area. Whilst the practice was not specifically aware of the most recent results of the GP survey and therefore had not implemented an action plan to improve performance, they were knowledgeable about patients' concerns regarding access. The practice were working closely with other stakeholders and practices in the locally to improve performance, and were continually looking at ways to improve the phone system. This included introducing telephone triage and promoting online access.

We spoke with the PPG who told us how they had influenced the practice, by suggesting changes to the telephone system and fundraising. There was a comments box in the waiting area, and if patients raised concerns, these were managed appropriately and discussed at relevant practice meetings.

Continuous improvement

The practice had engaged with other practices and stakeholders in a meaningful way, and had secured additional resources which sought to ensure that ongoing improvement could take place, specifically around access and care planning. From our first inspection visit of 8th August 2017 to our later visit of 5th September 2017, we saw evidence of new systems being implemented and

Are services well-led?

Inadequate

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

existing systems streamlined, although there were still areas where further improvements were required, particularly around safety, administrative functions and training.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not have systems and processes established and operated effectively to assess, monitor and improve the quality and safety of the services provided or to assess, monitor or mitigate risks to the health, safety and welfare of service users: Action plans were incomplete and systems were not effective in identifying that: Non-clinical staff did not receive an appraisal; Training was not consistently taking place or being recorded; Patients taking lithium were not being appropriately monitored; Patients who had learning disabilities were not receiving an appropriate annual review; There were no plans to improve performance in respect of exception reporting for one mental health indicator; The infection control audit had not been completed; Not all policies were fit for purpose; Not all recruitment or engagement checks had been undertaken before staff were employed or locums were engaged; There was no COSHH risk assessment. This was in breach of regulation 17(1) (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.