Half Penny Steps Health Centre

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Half Penny Steps Health Centre on 29 July 2015. The overall rating for the practice was good. The full comprehensive report can be found by selecting the 'all reports' link for Half Penny Steps health Centre on our website at www.cqc.org.uk.

This inspection was an unannounced focused inspection carried out on 22 May 2017 & 13 June 2017 in response to concerns received by the Care Quality Commission (CQC) that the practice was not providing safe care and treatment to its patients. The concerns specifically related to the practice having no lead GP and using locum GPs to run the service, without proper induction into practice procedures which included two week referrals and following up on hospital reports. There were also concerns in relation to there being no on site management support for staff and their lack of understanding of safeguarding vulnerable patients resulting in these patients being at risk. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection in relation to the GP practice only and not the 'walk-in' service.

At the inspection the concerns received by the CQC were substantiated and as a result a decision was made to take enforcement action against the provider where warning notices were issued for regulations 17; Good Governance and 18, Staffing.

Our key findings were as follows:

- The practice did not have systems in place for reporting and recording significant events and there was no evidence of learning and communication with staff about significant events.
- There were no formal systems and process in place to identify and assess risks to the health and safety of service users and staff. No assessment of the risk of, or preventing, detecting and controlling the spread of infections had taken place in the last two years.
- Staff had not received appropriate mandatory training such as basic life support or safeguarding.
- Patient outcomes were hard to identify as no clinical audits had been carried out to improve the quality of care and there was no evidence that the practice was comparing its performance to others; either locally or nationally.
- There were no processes in place for patients or staff to give feedback about the service.

Summary of findings

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed are available to meet the needs of 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 the duties.
- Ensure care and treatment is provided in a safe way to patients

We therefore intend to carry out a full comprehensive inspection of the whole service to asses whether the care being provided fo people using the service is safe and meets the standards set out in the Health and Social Care Act 2008 (Regulated Activities 2014).

If we find the practice is providing care that is unsafe we will take action in line with our enforcement procedures.

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?

- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence that the practice carried out investigations when there were unintended or unexpected safety incidents. Lessons learned were not communicated and so safety was not improved.
- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. We found staff had not received safeguarding or basic life support training, DBS checks had not been carried out on staff who acted as chaperones and there was no infection control audit carried out in the last two years.
- There was insufficient attention to safeguarding children and vulnerable adults. Staff were not able to recognise the signs of abuse.
- There was no evidence of electrical appliance safety tests taking place and calibration of equipment testing was out of date.

Are services effective?

- Although there was no evidence that audit was driving improvement in patient outcomes, data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- QOF exception reporting was 20%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice couldn't explain the high rates.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff.
- Clinical staff were aware of current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs

Are services well-led?

- There was no clear leadership structure and staff did not feel supported by management.

Summary of findings

- The practice had a number of policies and procedures to govern activity, but staff were not aware of them and these had not been reviewed in the last two years
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings which were not recorded.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group.
- Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

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.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed are available to meet the needs of 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 the duties.
- Ensure care and treatment is provided in a safe way to patients

Half Penny Steps Health 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 special advisor.

Background to Half Penny Steps Health Centre

Half Penny Steps Health Centre provides primary care services to around 4,940 patients living in West London. The practice holds an Alternative Personal Medical Services (APMS) contract with North West London Clinical Commissioning Group to deliver accessible primary care services to the local community, including people who are not formally registered with the practice. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice is part of a group of surgeries operated by the provider, Malling Health. The practice is managed day to day by a deputy practice-based manager and a lead GP and employs locum GPs to cover when the lead GP is not available. The practice also employs an advanced nurse practitioners (who lead on the walk-in primary care service), two locum practice nurses who work part-time, a health care assistant as well as a team of receptionists and administrators.

The practice is open between 8am to 8pm seven days a week, 365 days of the year including Christmas day and other public holidays. The practice offers both a bookable appointment system with GPs, the nurses and the health care assistant for registered patients and a nurse-led walk-in primary care service (which was not inspected at this inspected).

The practice provides patients with information about how to access urgent care when the practice is closed on its website, answerphone and on the practice door, primarily informing patients to telephone the 111 service.

The local population is very diverse in terms of levels of deprivation and household income with average life expectancy being similar to the national average.

Why we carried out this inspection

We inspected this service in response to concerns received by the Care Quality Commission that the practice was not always providing safe care and treatment to its patients.

This practice was previously inspected in July 2015 where they were rated good overall.

How we carried out this inspection

Before visiting, we reviewed information of concern received by the Care Quality Commission. We carried out an unannounced visit on 22 May & 13 June 2017. During the inspection, we looked at the premises at which the

Detailed findings

regulated activities were being provided, documentation relating to the management of the regulated activities and spoke with staff who were involved in providing the regulated activities.

Are services safe?

Our findings

We carried out an unannounced inspection at Half Penny Steps Health Centre on 22 May & 13 June 2017 in response to concerns received by the Care Quality Commission (CQC) that the practice was not providing safe care and treatment to its patients.

The practice was inspected in July 2015 and at that time was rated 'good', however since then there has been three changes in practice manager and there is currently no practice manager in place. Further, the long term GP had left which has resulted in the practice using locums to provide the service until a salaried GP was employed in May 2017.

Safe track record and learning

- The practice did not have a system in place for reporting and recording significant events. The Service Development Manager told us they did have a procedure for reporting and recording incidents but were not able to find it. Staff we spoke with were also not clear about their responsibilities to raise concerns or the process of formally reporting incidents and near misses. They told us that when incidents had occurred with patients they would report it to a GP or a manager and would make a note in the patients' medical records. We were given examples of incidents that had occurred this year but staff were unable to show us where these were recorded.
- There was no evidence of wider discussion with the practice team regarding learning points and no minutes of meetings with incidents or significant events on the agenda.
- The lead GP told us they were not aware of any formal processes in place for dissemination or discussion of national patient safety alerts.

Overview of safety systems and process

The practice had some processes and practices in place to keep people safe and safeguarded from abuse but substantial improvement was required.

- There was a safeguarding policy and procedure, however, it was not practice specific and did not contain details of who the practice safeguarding lead was. The GP told us they were the safeguarding lead, but they had only been at the practice since the beginning of May 2017 and were in the process of familiarising themselves with the practice procedure. We saw local contact details were displayed on the walls in the treatment rooms. However, staff were not aware of who the lead was and had not received any training on safeguarding children or adults. Further, they were not aware of their responsibilities to share information with the relevant agencies.
- There were notices in the waiting room advising patients that chaperones were available if required. However, the staff who acted as chaperones had not been trained for the role and had not received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- Although we observed the premises to be generally clean and tidy. We were told that the lead GP was the infection control lead, however they were not familiar with the practices infection control procedures and did not know when the last audit had taken place. Further, there were no cleaning records available.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice had started carrying out medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Processes were in place for handling repeat prescriptions however, blank prescription forms and pads were not securely stored and there were no systems in place to monitor their use. There was no evidence to show that Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)
- We reviewed six personnel files and found that most recruitment checks had been undertaken prior to employment. For example, proof of identification,

registration with the appropriate professional body for staff and that appropriate checks had been carried out through the Disclosure and Barring Service for clinicians.

Monitoring risks to patients

Risks to patients were not assessed or well managed.

- There were some procedures in place for managing risks to patients and staff. The Service Development Manager showed us a health and safety procedure which included a 'compliance system'. However, staff we spoke with were not aware of it. Further, a health and safety lead had not been identified and they were unable to tell us when the last audit had been carried out.
- The calibration of clinical equipment to ensure it was working properly had not been carried out since January 2016. There was no evidence to confirm when the last electrical equipment testing (PAT) had been carried out.
- There were no arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs and keep people safe. The patient list size was 5000 and a daily 'walk-in' clinic was provided for local people who were not registered at the practice. We observed that patients attending that clinic became upset when they were unable to see a GP after being told the nurse practitioner was unable to address their concern. The Service Development Manager was unable to provide any evidence to show that the practice had reviewed the capacity of GPs needed to meet the needs of people using the service.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Staff had not received annual basic life support training.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. However, it did not contain an up to date staff list with emergency contact numbers.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and told us they accessed them from the National Institute for Health and Care Excellence (NICE). However, the practice did not have any procedures in place to monitor that these guidelines were followed.

Management, monitoring and improving outcomes for people

The lead GP had only been in post for one month, however they told us they used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available, with 20% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice were unable to give a reason as to why their exception reporting was so high.

Data from QOF showed:

- Performance for diabetes related indicators was 90%, which was above the CCG of 84% and comparable to the national average of 90%. However, there was 38% exception reporting for patients with diabetes, on the register, in whom the last IFCC-HbA1c result was recorded in the preceding 12 months.
- Performance for mental health related indicators was 86%, which below the CCG average of 88% and the national average of 89%. However, there was 18% exception reporting for patients with mental health concerns who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months.

There was no evidence of quality improvement including clinical audit. The practice had been staffed by a series of locum GPs for the past three months. The salaried GP was employed in May 2017 and told us they had not carried out any clinical audits as yet.

Effective staffing

We found the practice was unable to evidence staff had the skills and knowledge to deliver effective care and treatment.

- The practice had a combination of newly appointed staff and used locums in both clinical and administrative roles. Staff we spoke with said they had not received an induction or where they had, it was limited to being told how to exit the building in an emergency and being trained to use SystemOne, a clinical records system. We saw the practice had an induction pack that provided basic information such as evacuation procedures, emergency equipment and computer logins. However, there was no reference to any policies and procedures or topics such as infection prevention and control, health and safety and confidentiality.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. There were no training records to evidence that staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- The practice did not have a process for identifying the learning needs of staff. Staff told us they did not have supervisions, appraisals or practice meetings.

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.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

We saw that the GP had facilitated a meeting with other health care professionals in the month they started, where care plans were reviewed and updated for patients with complex needs.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

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 and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services well-led?

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

Our findings

Governance arrangements

The practice had limited governance arrangements.

- The practice did not have appropriate arrangements in place to ensure there were adequate on site managerial support. There was no managerial presence when we arrived for our inspection and staff told us this was a frequent occurrence. They said there had been occassions where incidents had occurred and there was no one to inform and/or seek guidance from.
- Staff we spoke with were not aware of any procedures any procedures for reporting, recording and learning from incidents.
- Staff we spoke with were not aware of any of the key policies and procedures in place such as safeguarding, health and safety, equality and diversity, and whistle blowing.
- The Service Development Manager, could not tell us when the last Health & Safety audit had been carried out or who the lead member of staff was. Further, they were not aware of any formal processes to ensure clinical staff received appropriate information in relation safety alerts of NICE guidance.
- There was no programme of quality improvement and no clinical audits had been completed.
- We saw evidence to confirm that they lead GP had started to discuss QOF data at the monthly clinical meeting.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, all patients deemed vulnerable had risk assessments in their records.

Leadership and culture

The practice did not have any evidence to show they were aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents.

Staff told us that when manager were around they did not find them approachable. They said they did not feel well supported and were not involved in discussions about how to run and develop the practice.

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

The practice did not have any processes in place to encourage feedback from patients, the public and staff.

- They did not have a patient participation group (PPG), had not carried out any surveys and did not have a system to monitor complaints received. Staff were not aware of the complaints policy and there was no process for logging written or verbal complaints. However, the Service Development Manager told us they had responded to some complaints when on site and the GP showed us evidence that they had had responded directly to three patient complaints they had received since being employed.
- They did not gather feedback from staff as they did not have staff meetings or carry out appraisals. Staff were not actively encouraged to raise concerns. All staff we spoke with told us they had not been asked for their feedback and had not had the opportunity to discuss any concerns or issues with colleagues and management.

Continuous Improvement

There was no evidence of continuous improvement.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • We found that you did not have appropriate arrangements in place to ensure the practice had adequate on site managerial support • We found there were no procedures in place for reporting, recording and learning from incidents and significant events. • There was no formal systems and process in place to identify and assess risks to the health and safety of service users and staff. • We found that did not have systems in place for staff to receive appropriate support

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 **How the regulation was not being met:** • We found staff had only received SystemOne training since being employed. They had not received any of the organisations mandatory training, such as Health and Safety, infection control, safeguarding or information governance. • We found that staff had not received any supervision or appraisals to enable them to carry out their role