# Dr Ijaz Hayat

## Quality Report

Hayat Medical Centre,
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London
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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? | Inadequate |
| Are services responsive to people's needs? | Inadequate |
| Are services well-led? | Inadequate |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out a comprehensive inspection of Hayat Medical Centre on 22 and 23 October 2014. In addition to asking the five questions the inspection followed up on serious concerns highlighted at previous inspections. Overall the practice is rated as inadequate.

Specifically, we found the practice to be inadequate for providing safe, effective, caring, responsive and well-led services. It was also inadequate for providing services for the care provided to older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. Staff were not clear about reporting incidents, near misses and concerns and there was no processes in place to learn from significant events.
- Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines.
- We found treatment and care of patients was variable and patients were not satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff.
- The practice failed to engage with commissioners and other agencies to improve its services and promote the care and welfare of patients.
- Access to the surgery by telephone and wait times for appointments were poor and patients reported delays in being seen for booked appointments.
- There was no clear leadership structure and administrative and governance systems were significantly lacking.
- Staff were not clear about their responsibilities and did not feel supported by management.
- There were areas of practice where the provider needs to make improvements

Importantly, the provider must:

- Make suitable arrangements for training relevant staff in safeguarding and child protection.

# Summary of findings

- Put in place systems to audit, manage, respond to and learn from incidents, complaints and occasions when things go wrong.
- Ensure that patients records kept securely and can be located promptly when required.
- Ensure that recruitment checks are carried out for all staff prior to employment
- Ensure that any staff that carry out chaperone responsibilities have been trained and can evidence a satisfactory DBS disclosure.
- Ensure that patients receiving repeat prescriptions are regularly reviewed by the GP.
- Ensure that prescription forms are handled in accordance with national guidance and stored safely.
- Make suitable arrangements to ensure medicines are appropriately stored and that fridge temperatures are taken and recorded in line with recognised guidance.
- Make suitable arrangements for leadership, training and implementation of effective infection control measures.
- Ensure arrangements are in place for annual testing of all electrical equipment.
- Ensure appropriate arrangements are in place to respond to emergencies.
- Put in place systems to ensure that patients receive the treatment and care relevant to their condition, including routine reviews of patients with long term conditions.
- Ensure that all staff are appropriately trained, supervised and appraised.
- Put in place systems to manage risk, including procedures and audit to monitor effective assessment and implementation of actions identified.
- Ensure audit cycles are undertaken.
- Implement clear leadership structures and ensure staff are made aware of governance arrangements.
- Ensure patients are enabled to make or participate in decisions relating to their care or treatment.

In addition the provider should:

- Make suitable arrangements for working with other health and social care professionals to ensure patients with complex needs or priority conditions are discussed, and agreed appropriate action taken.
- Make appropriate arrangements in place to protect patients privacy and dignity.

**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 safe and improvements are required. Staff were not clear about reporting incidents, near misses and concerns. When things went wrong it was not clear whether reviews were undertaken. There was no evidence of learning and no communication with staff. There was no opportunity to improve safety. Patients were at risk of harm because systems and processes were not in place to keep them safe. There was no evidence that appropriate learning had taken place following significant events or that the findings were disseminated to relevant staff.There was insufficient information to understand and be assured about safety because the practice did not maintain a risk log.

Inadequate

**Are services effective?**
**INADEQUATE**
The practice is rated as inadequate for effective and improvements are required. Data showed that care and treatment is not delivered in line with recognised professional standards and guidelines. Patient outcomes were hard to identify as little or no reference was made to audits nor was there evidence the practice was comparing its performance to others – either locally or nationally. There is minimal engagement with other providers of health and social care. There is limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required. Basic care and treatment requirements are not met.

Inadequate

**Are services caring?**
**INADEQUATE**
The practice is rated as inadequate for caring and improvements are required. Data showed the patients rated the practice lower than others for many aspects of care. Feedback from patients on how well they were treated included examples of where they were not treated with respect and staff lacked compassion. Insufficient information was available to help patients understand the care available to them.

Inadequate

**Are services responsive to people's needs?**
**INADEQUATE**
The practice is rated as inadequate for responsive and improvements are required. The practice had not reviewed the needs of their local population. The practice was not working with the NHSE Local Area Team (LAT) and Clinical Commissioning Group (CCG) to review information about the local population and to

Inadequate

# Summary of findings

secure service improvements. Patients reported considerable difficulty in accessing a named GP and poor continuity of care. Appointment systems were not working well and needed review to ensure patients received timely care when they needed it. Information was provided for patients regarding the complaints system but this was not accessible to all patients and was insufficient.

**Are services well-led?**
**INADEQUATE**

The practice is rated as inadequate for well-led.The practice did not have a clear vision and strategy to deliver this.The registered manager is the individual partner. He demonstrated a lack of insight into the functions of the role of registered manager or that of lead partner. Staff we spoke with were not clear about their responsibilities in relation to this.There was no clear leadership structure and staff did not feel supported by management.The practice had a number of policies and procedures to govern activity; however these had not been reviewed to ensure they were relevant to this practice.The practice did not hold regular governance meetings and issues were discussed at ad-hoc meetings.The practice had not proactively sought feedback from staff and did not have a patient participation group (PPG).Staff told us they had not received regular performance reviews and did not have clear objectives.

**Inadequate**

# Summary of findings

## What people who use the service say

We spoke with six patients during our inspection and received 21 completed Care Quality Commission (CQC) feedback cards.

Most of the patients we spoke with had been transferred to the practice within the last few years, when two local practices closed. They told us they had not received consistently good care since joining the practice. All the patients we spoke with during the inspection told us they were not satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff.

We looked at the completed CQC comment cards; 50% was very positive about the practice, however the others expressed concern about the difficulty in contacting the surgery to book appointments and the lack of consistency in diagnosis from the locum doctors.

In the most recent patient survey carried out by the CCG, accessing appointments and treatment and care had scored very low.

The practice is rated as 1.0 star out of 5 for their overall service on NHS Choices, with appointments scoring 1.5 and dignity and respect 2, out of 5.

## Areas for improvement

**Action the service MUST take to improve**

Staff we spoke to were not aware who the safeguarding lead was. The lead GP told us they were the lead for two days a week and when they were not in, the responsibility was delegated to either the practice manager or a locum doctor. However they said they had not asked the locums if they had completed safeguarding training.

We were told reception staff had acted as chaperones but had not received chaperone training and had not understood their responsibilities when acting as chaperones. Those who had undertaken chaperoning responsibilities has not had Disclosure and Barring Service (DBS) checks.

The GPs and nursing staff we spoke with could not clearly outline the rationale for their treatment approaches. We were told clinical meetings had not occurred at the practice for more than a year.

We found staff did not carry out regular checks to ensure that patients receiving repeat prescriptions had been reviewed by the GP.

There was no process in place to monitor that all routine health checks were completed for long-term conditions such as diabetes.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely. Rooms, cupboards and the refrigerator were not locked when the room was unoccupied and the keys were left in the room in clear view.

We saw that neither of the two thermometers for the fridge could record minimum or maximum temperatures. This is contrary to Public Health England (PHE) guidance for the storage of vaccines and the practice's own policy which stated 'minimum, maximum and actual temperatures will be monitored each day'.

Blank prescription forms were not handled in accordance with national guidance as we saw that they were left insecure and accessible to unauthorised people. The practice's policy for prescription security made no reference to the recording or security of in use prescriptions.

The practice manager told us the lead for infection control was the practice nurse. However, the nurse was not aware they were the lead and none of the administration staff we spoke with knew who the lead was.

No arrangements were in place for multi-disciplinary (MDT) meetings. The practice was unable to evidence any formal multi-disciplinary working arrangements with other health and social care professionals.

# Summary of findings

The practice did not have any clear governance arrangements in place. The registered manager did not understand his responsibilities in relation to managing the practice. He had been away from the practice for extended periods over the past year and had not clearly delegated his responsibilities to anyone at the practice.

The practice did not have any systems in place to monitor and manage risk.

The practice had not shared with staff any completed reviews of significant events or other incidents.

The practice had not completed any audit cycles.

The practice manager and the reception staff told us they did not have job descriptions and we found that there were no references on file for some members of staff.

Reception staff told us they had not received an induction or attended any other training.

There were no records to show that portable electrical equipment was routinely tested or had been tested recently.

Appropriate arrangements were not in place to respond to emergencies.

# Dr Ijaz Hayat

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included two GP Specialist Advisors, a second Inspector, a Specialist Advisor Practice Manager and a Specialist Advisor Pharmacist. All members of the inspection team were granted the same authority to enter registered persons' premises as the CQC inspectors.

## Background to Dr Ijaz Hayat

Hayat Medical Centre is situated at 273 Boundary Road, London, E17 8NE. The practice provides primary care services through a General Medical Services (GMS) contract to approximately 6000 patients in the local area. The practice is part of the NHS Waltham Forest Clinical Commissioning Group (CCG) which is made up of 45 GP practices that serve a population of 292,000.

The practice is located in a converted terraced property with all patient accessible areas on the ground floor, a ramp provides access to those using a wheelchair. The practice serves a younger population group with patients predominantly in the 25-34 years age range. Twenty five percent of patients are young people and children under 18 years of age which is higher than both the CCG and national averages, whilst only 7.6% of patients are over 65 years of age, below the CCG and national averages.

The practice serves a population predominantly comprised of ethnic minorities including patients of Bengali and Arabic origins. The practice scores low in terms of the levels of deprivation across its geographical community. There is a high prevalence of diabetes among patients of the practice.

The practice is registered with the Care Quality Commission to provide the regulated activities ofdiagnostic and screening procedures, treatment of disease, disorder and injury.

The practice staff comprise one male lead GP, Dr Hayat, who is both provider and Registered Manager of the practice. At the time of the inspection Dr Hayat was limited in the clinical activity he could provide as a consequence of conditions on his GMC registration. A number of locum GPs made up the clinical establishment, with two (one male, one female) offering regular sessions to provide a degree of continuity and afford same gender preference to patients. It was noted, and the practice acknowledged, that the relatively high volume of locum GPs caused issues with continuity, communication and accountability.

The inspection was conducted to assess the five questions relating to Safety, Care, Effectiveness, Responsiveness and Leadership, however it was also assessing progress against significant concerns highlighted at previous inspections. During 2013/14 CQC conducted four statutory inspections of the practice; on each occasion the practice failed to demonstrate that the essential standards were met. Enforcement action was taken, and at this inspection an assessment was made to determine whether the practice had met with the requirements of that enforcement action.

Out of hours services are not provided by the Hayat Medical Centre, patients calling the surgery when it is closed are directed to NHS 111 if they require the services of a GP.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

# Detailed findings

We carried outa comprehensive inspection of this serviceunder Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Concerns had previously been noted at the practice and enforcement action has been taken. This inspection therefore made follow up enquiries in respect of the outstanding matters published in our inspection reports relating to inspections conducted on:

- 23 October 2013
- 3 January 2014
- 11 February 2014
- 21 March 2014

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.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

We looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch and NHS England , to share what they knew about the service. We carried out an announced visit 22nd and 23rd October 2014. During our visit we spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Inadequate

# Are services safe?

## Our findings

### Safe Track Record

The practice did not have a clear system in place to identify risks and improve quality in relation to patient safety. Staff we spoke to were aware of their responsibilities to raise concerns, however were not clear about how to report incidents, near misses and concerns, but said they would tell either the practice manager or office manager if any incidents occurred. We received a significant event log which detailed incidents that had occurred between December 2013 and October 2014. However there was no evidence to show that the practice had taken action to prevent these incidents occurring again.

The lead GP told us the practice did not have a risk log and did not have systems in place to check safety and effectiveness of clinical provision.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. We saw practice meeting notes for the past three months and saw that whilst significant events had occurred during this period, they had not been discussed at these meetings and separate significant events meetings were not held to review actions from past significant events and complaints. There was no evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff.

We were told incident forms were available, however staff were unable to locate one during our inspection. Once completed these were sent to the practice manager who told us it was their responsibility to ensure the appropriate action was taken. However, the practice were unable to evidence any action taken as a result of incidents that had occurred.

The practice manager told us national patient safety alerts would be sent directly to them and they would then circulate to doctors. We asked what would happen if she was not in. There was no scheme of delegation and no written procedure for staff to follow in her absence meaning that all safety alert, would not be circulated until shereturned.

### Reliable safety systems and processes including safeguarding

The practice had some systems in place to manage and review risks to vulnerable children, young people and adults.All staff we spoke with said they had attended some safeguarding training. Two administrative staff told us they had completed child protection training and adult safeguarding online this year. There were no records to confirm when the training had occurred and to what level. We saw clinical staff had been trained to Level 3 in child protection. The practice manager and the GP's told us they had attended adult safeguarding training.

Most staff knew how to recognise signs of abuse children but were not aware of their responsibilities regarding information sharing and documentation of safeguarding concerns or how to contact the relevant agencies in and out of hours.However, we saw multi-agency safeguarding information and contact details were displayed in some of the treatment rooms.

Staff we spoke to were not aware who the safeguarding lead was but said they would speak to the practice manager if they had a concern. The lead GP told us they were the lead for two days a week and when they were not in, the responsibility was delegated to either the practice manager or a locum doctor. However, they said they had not asked the locums if they had completed safeguarding training.

We were told the practice did not have a system to highlight vulnerable patients on the practice's electronic records. Therefore staff were unaware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms.However, we were told reception staff had acted as chaperones but had not attended chaperone training and had not understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. They told us they would stand behind the curtain out of view of the examination when chaperoning. DBS checks for non-medical staff acting as chaperones had not been obtained.

Patient's individual records were written and managed in a way to help ensure safety.Records were kept on an electronic system which collated all communications

about the patient including scanned copies of communications from hospitals. However, we were told that the licence for using a document management software tool had not been renewed since expiry. This meant that it was not possible to assess an audit trail of how documents coming into and leaving the practice were actioned. The lead GP told us manual audits had not been carried out to assess the completeness of these records and action had not therefore been taken to address any shortcomings identified at inspection.

Arrangements existed for the storage of archived 'Lloyd George' notes (manual, handwritten patient records), although the storage facility was in disarray at the time of inspection. Whilst the majority of records were shelved alphabetically, several large sacks filled with random records were observed together with a number of patient files that had been left opened with the contents not replaced in their sleeves. Administrative staff commented that locating a specific Lloyd George record swiftly would be challenging (effectively searching through several sacks of random records) as a consequence of the disorder at the time of inspection.

### Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were not stored securely. Neither the rooms, cupboards or the refrigerator were locked when the areas were unoccupied and keys were left in clear view.

The practice had a policy for the storage of medicines dated 1st August 2014 which stated that 'all medicines kept in the premises will be stored securely'. We saw vaccines had been left on the desk in the treatment room when the nurse was away from the premises. When checked we found them to be warm to the touch and there was no record of how long they had been removed from cold storage.

We saw that the temperature of the medicines refrigerator was checked daily Monday to Friday. However we saw that neither of the two thermometers for the fridge could record minimum or maximum temperatures. This is contrary to Public Health England (PHE) guidance for the storage of vaccines and the practice's own policy which stated 'minimum, maximum and actual temperatures will be monitored each day'. The temperature recorded for the day of our visit and the previous day was 4 degrees Celsius, however we noted that both thermometers were recording a temperature of -1c. We asked the nurse, who had recorded the temperature on both days of inspection to identify how she determined the temperature. She demonstrated that she read the setting on the fridge and made no reference to either of the thermometers; she told us that this was how the temperature was routinely taken. This meant that there was no accurate record of the fridge temperatures and we were concerned that the vaccines in the fridge had been stored at a temperature below freezing point for an unknown time.

We advised the practice to immediately seek advice from PHE and to make alternative arrangements for any vaccination appointments they had that afternoon.

All the medicines we checked were within their expiry dates and we saw that they had been checked on 30 September 2014; however we did not see any records of regular checks to ensure that medicines were replaced in a timely manner.

Vaccines were administered by nurses using patient specific directions that had been reviewed and approved in line with national guidance.

Repeat prescriptions were managed in the practice by different members of staff, depending on availability. We heard from patients and healthcare professionals that there were serious delays for some people receiving their prescriptions and being able to get their medicines in time. People were left without essential medicines and had to make alternative arrangements. Notices in the practice told patients that their prescriptions would be ready in 48 hours; however people told us that this was not the case. The requests were not date stamped when they were received so it was not possible to audit the process. The practice's repeat prescribing protocol set out situations where medication reviews or blood tests would be needed before issuing the prescription.

In light of concerns regarding the safety of the repeat prescribing system a detailed records review was undertaken. Of 100 patient records checked, 12 records showed that the patient had had a medication review allowing repeat prescriptions to be issued safely. In 88 of the records the review date was overdue yet repeat prescriptions had continued to be issued. The items that had been issued in records where the review was overdue

included one for controlled drugs and three for sleeping pills (Zopiclone). This evidence confirmed that the repeat prescription system was not functioning and was resulting in unsafe medicines management.

Blank prescription forms were not handled in accordance with national guidance as we saw that they were left insecure and accessible to unauthorised people. The practice's policy for prescription security made no reference to the recording or security of in use prescriptions.

### Cleanliness & Infection Control

We observed the premises to be mostly clean and tidy. Although we found low level dust on the skirting boards in some consultation rooms and under the head rest of the couch in one surgery. There were no cleaning schedules in place and cleaning records were not kept. We were told a cleaner was employed on a daily basis.

The practice manager told us the lead for infection control was the practice nurse. However, the nurse was not aware they were the lead and none of the administration staff we spoke with knew who the lead was. We saw evidence an audit had been carried out in March 2014. This had identified a number of actions to be completed.For example occupational health assessments, a uniform policy, a single use instrument policy and measures to be put in place to prevent the medicines fridge being switched off. The practice were unable to confirm whether these actions had been completed.

We asked for an infection control policy but the practice was not able to locate this during our inspection. Staff told us they had not received any infection control training. One person told us they had read the infection control policy but was not sure where it was kept. The nurse told us personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Reception staff said they would not handle specimens without wearing gloves. The cabinet where specimens were placed was located in the waiting room and could be opened by other patients or children. We drew this to the attention of the practice manager who told us it was usually kept locked.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw the practice had a legionella (a germ found in the environment which can contaminate water systems in buildings) risk assessment carried out in June 2014 however, they were not following the recommendation of testing the water regularly in order to reduce the risk of infection to staff and patients.

### Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. There were no records to show that portable electrical equipment was routinely tested. The practice did not have a schedule of testing in place.We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure machines was carried out in April 2014.

### Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had not been undertaken prior to employment. For example there were cases where references had not been taken up and criminal records checks via the Disclosure and Barring Service could not be evidenced. Further, some CV's contained gaps in employment history and the practice had not sought explanations for these gaps. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff which was not being followed.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. However, we saw there were two days in the last year when there was no doctor available at the practice as they were unable to get to the surgery due to road closures for an event. We asked why arrangements had not been put in place to address this as the event had been advertised for some time.We were told the practice had not expected it to cause such disruption on the roads.

The practice manager told us they were aware that GP staffing levels were too low.They said that one locum had agreed to increase their sessions at the surgery in November 2014. Patients we spoke with told us they felt there were not enough nursing staff at the practice as the nurse only worked 1.5 days a week. Some patients told us

Inadequate

# Are services safe?

their children had not received their immunisations on time as the nurse was often not available. The reception staff told us they would send people to the walk-in clinic on occasions when the nurse was not available.

### Monitoring Safety & Responding to Risk

The practice had some processes in place to manage and monitor risks to patients, staff and visitors to the practice.There was no evidence that a complete risk assessment of the practice had been carried out. However, we saw that a fire risk assessment had been carried out in June 2014. This had identified the need for weekly fire alarm checks, to develop a fire evacuation procedure, fire doors not closing properly, staff training in the use of fire equipment, service fire extinguishers.We saw that monthly checks on fire doors had been carried out in July 2014 and the fire alarm check had been carried out weekly until August 2014.The practice manager told us they had planned to restart the checks in November 2014.We saw fire extinguishers had not been serviced since August 2013. Staff told us they were not aware of a fire evacuation procedure and had not been trained to use the fire equipment.

The practice had a health and safety policy, howevernamed roles identified in the in the policy for people to report concerns to, had not been completed. We drew this to the attention of the practice manager who said they would review the policy.

We saw evidence that a Health and Safety audit had been carried out in July 2014 by an external contractor. This had identified a number of areas for the practice to take immediate action, such as for the practice to carry out a lone worker risk assessment, to undertake testing of emergency lighting and to share the finding of the audit with staff. We were told these actions had not yet been completed due to staff changes.

### Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. We saw records showing that some but not all staff had received training in basic life support.Emergency equipment was available including oxygen and an Automated External Defibrillator (AED), used to attempt to restart a person's heart in an emergency. All staff asked knew the location of this equipment. However, the practice failed to evidence that there were persons trained in the use of the AED at all times when the surgery was open. Additionally, there were no records to evidence this equipment had been checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Reception staff told us they would always dial 999 and call an ambulance if a doctor was not available to deal with a medical emergency.

The practice did not have a business continuity plan in place.The practice manager told us they were in the process of drafting one.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GP's told us they occasionally used National Institute for Health and Care Excellence (NICE) guidelines for diagnosis and treatment options. They were however, unable to give us any examples of when they had recently used them.

The GPs and nursing staff we spoke with could not clearly outline the rationale for their treatment approaches.

We were told clinical meetings had not occurred at the practice for more than a year.

National data showed referral rates to secondary and other community care services for all conditions was amongst the lowest in the borough. However, the lead GP was unable to tell us what had been done to understand the implications of this finding. .

### Management, monitoring and improving outcomes for people

The practice showed us some evidence of incomplete clinical audits such as antibiotic prescribing and medication review. However, there was no evidence of any completed audits.

The practice was also unable to evidence how they used the information they collected for the QOF. They told us that they did not assess their performance against national screening programmes to monitor outcomes for patients. The lead GP was unclear what their QOF result was for last year and could not locate a copy of the last QOF report.

We found staff did not carry out regular checks to ensure that patients receiving repeat prescriptions had been reviewed by the GP.

Staff did not monitor that all routine health checks were completed for long-term conditions such as diabetes. The IT system did not flag up relevant medicines alerts when the GP went to prescribe medicines.

We did not see any evidence to confirm that the GPs had oversight or a good understanding of the best treatment for each patient's needs.

The practice did not participate in any local benchmarking run by the CCG.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Reception staff told us they had not received any form of induction or attended any role specific training. Review of staff files showed no evidence of induction for administrative staff.

One GP who was a regular locum told us they were up to date with their yearly continuing professional development requirements and had been revalidated in April 2014. The Lead GP was receiving professional support from NHS England towards their revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England).

The practice manager told us all staff undertook annual appraisals which identified learning needs from which action plans were documented – although these were not available for inspection. However, reception staff told us the practice was not proactive in providing training, instead they had been told to read relevant policies, for example that relating to infection control.

The practice nurse had defined duties they were expected to perform (for example cervical cytology) but was unable to demonstrate they were trained to fulfil these duties.

### Working with colleagues and other services

The practice did not work effectively with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received by post or fax and which were placed into a box at reception. We were told that each day a named GP would check the box and take whatever action is required.The practice manager told us they would also check the box at the end of the day to ensure all tasks relating to results had been actioned. However, we noted the box was not checked at the end of our first inspection day and when we returned the next day the same results were in the box.

We were told that the practice manager confirmed that pathology results were all checked and actioned daily. However we found that 57 pathology results had not been checked in the preceding two days and that 12 of the 57 unactioned results showed abnormal blood results.

Inadequate

# Are services effective?

## (for example, treatment is effective)

The practice did not have a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received.There was evidence of instances within the last year where results or discharge summaries were not followed up appropriately for several months. The practice did not have a document management tool in place as the licence had not been renewed.

No arrangements were in place for multi-disciplinary (MDT) meetings. The practice was unable to evidence any formal multi-disciplinary working arrangementswith other health and social care professionals.The GP said they contacted health visitors, district nurses and social workers when they needed to exchange information about patients using a standard form.

### Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. Reception staff told us they were 'shown' how to use the system by the practice manager. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference but did not enable an audit trail to be undertaken to assess the effectiveness and safety of the process that was now in place.

We were told the Choose and Book system was in place for making referrals, however it was not currently being used. Referrals were made by fax or post, making audit and review particularly challenging to carry out.

### Consent to care and treatment

We were told that GP's were aware of the Mental Capacity Act 2005 and understood the key parts of the legislation. However they were unable to describe how they implemented it in their practice.

All clinical staff we spoke with described a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). We were unable to identify records that supported this.

### Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. We noted the GPs would sometimes use their contact with patients to help maintain physical health and wellbeing. For example, by offering opportunistic flu jabs to older and vulnerable people.

The practice was not aware of how they were performing in regarding cervical smear uptake. There was no system in place for following-up patients who did not attend cervical screening.Similarly there was no mechanism of following up patients who did not attend for screening programmes for mammography and bowel cancer.

The practice stated that it offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was below average for the CCG.The practice did not have a policy for following up non-attenders by the practice nurse and had not taken any action to improve their immunisation rates.

The practice kept a register for people with learning disabilities. We saw that of the 72 people registered approximately 10 per cent had care plans and had physical health checks carried out in the last year.

Inadequate

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 42 patients undertaken by the practice.

The evidence from the internal survey showed most patients were satisfied with how they were treated and that this was with compassion, dignity and respect. However, the evidence form the national patient survey showed that approximately 50% of respondents were not satisfied with how they were treated. For example, data from the national patient survey showed the practice was rated 'among the worst' compared to other practices in the CCG area. The practice was also below average for its satisfaction scores on consultations with doctors and nurses with 59% of practice respondents saying the GP was good at listening to them and 48% saying the GP gave them enough time.

We received 21 completed CQC comment cards and 11 were positive about the service experienced. Patients said they felt the practice staff were helpful and caring. They said some staff treated them with dignity and respect. 10 comments were less positive with some of the common themes being notbeing able to see the same doctor, not being treated with dignity and respect, the doctor not being caringand that they did not feel listened to.

We also spoke with six patients on the days of our inspection. All told us they were not satisfied with the care provided by the practice.Common themes included not being to see the same doctor. They told us that they often they got different diagnosis from different doctors and that they had to wait a long time after their stated appointment to be seen. They told us that when they were seen they were not treated with dignity or respect by some of the locum doctors.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in some consulting rooms, however we found three treatment rooms where there were no curtains, therefore patients' privacy and dignity was not always maintained during examinations, investigations and treatments. We noted that treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff did not always follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located close to the reception desk and although it was shielded by glass partitions patients waiting at reception could hear confidential information being discussed on the phone. Due to the position of the reception desk and the system in operation we noted that it was difficult to maintain confidentiality when speaking to patients at reception. We saw patients overhearing potentially private conversations between patients and reception staff.

Reception staff told us that on occasions they felt vulnerable behind reception as quite a number of patients often displayed threatening behaviour. They told us they had requested some training on how to defuse potentially difficult situations but they had not received it as yet.We noted there was no notice in the patient reception area stating the practice's zero tolerance for abusive behaviour

We observed that staff did not always treat people whose circumstances may make them vulnerable, in a sensitive manner. For example older patients and patients with learning disabilities were turned away from reception when they attended the surgery for emergency appointments and were told to try again the next day. We asked whether staff had received training on how to deal sympathetically with all groups of people and was told that they had not.

### Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded negatively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice poor in these areas. For example, data from the national patient survey showed 38% of practice respondents said the GP involved them in care decisions and 55% felt the GP was good at explaining treatment and results. Both these results were below average compared to the CCG area. The results from the practice's own satisfaction survey showed that 85% of patients said they were sufficiently involved in making decisions about their care.

Inadequate

# Are services caring?

Patients we spoke to on the day of our inspection told us that health issues were not discussed with them and they did not feel involved in decision making about the care and treatment they received. They also told us they did not feel listened to and supported by staff and did not have sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was mixed about these views i.e. approximately 50% felt they were listened to and involved in the decision making.

Staff told us that translation services were available for patients who did not have English as a first language. However, they said they very rarely used them as staff at the practice spoke most of the relevant languages which were Hindi and Urdu. We did not see any notices in the reception areas informing patients that a translation service was available.

### Patient/carer support to cope emotionally with care and treatment

Patients we spoke to on the day of our inspection were not positive about the emotional support provided by the practice. They felt staff did not respond compassionately when they needed help, for example, to access counselling services or support for carers looking after someone with Dementia. GP's said they had not referred anyone to other services for support. We observed there were no notices in the patient waiting room signposting people to support groups and organisations.

Patients we spoke to who had had bereavement told us they had not received appropriate support from the practice. Some said they had not been contacted by the doctors at all and others stated it had taken some time to get death certificates.

Inadequate

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice was unable to demonstrate an understanding of the needs of the local population.

Information we received before the inspection indicated that Waltham Forrest hadsignificant levels of under-reporting or under-diagnosis in primary care for dementia, low levels of child immunisation rates.

There had been a high turnover of staff during the last year and when we inspected the care and treatment was being provided by locum GP's, which had impacted on the practices ability to provide continuity of care and accessibility to appointments with a GP of choice. Longer appointments were not available for people who needed them and those with long term conditions. We were told by the practice manager that the locum GPs had refused to carry out home visits.However, the practice had made arrangements for a new locum to provide home visits from November 2014. The GP's we spoke with told us they would carry out home visits in urgent circumstances such as to see patients who were house-bound. This was at odds with what we had been told by the practice manager.

The practice did not have a Patient Participation Group (PPG). However, they had carried out their own patient survey in June 2014 and had developed an action plan to address the areas of concerns that patients had fed back, such as to promote the on-line booking system, to provide information to patients on where they can go for minor ailments and to expand the on-line system to allow for patients to order repeat prescriptions.

The practice did not have a palliative care register and did not have regular internal or multidisciplinary meetings to discuss patients and their families care and support needs.

### Tackling inequity and promoting equality

The practice had access to online and telephone translation services and the GP's and practice nurse spoke the main relevant languages such as Urdu and Hindi.

The premises and services had been adapted to meet the needs of people with disabilities, for example, there was a ramp at the entrance.We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms, which were located on the ground floor. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

### Access to the service

Appointments were available from 9am to 6pm on weekdays. They are closed to patients between 12pm and 3pm. The last appointment time is 5.50pm.

The practice did not have a website, however they had set up on on-line booking system. Patients were able to book all types of appoints including urgent appointments and home visits. Patients had however complained that they were unable to access the online system, and shortly after the inspection the online booking system was found to be unavailable. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances.

Patients told us and had highlighted in the survey, that the practice did not provide information about how to access the out of hours service.The practice manager told us they would ensure more information was made available to patients on the out-of-hours service.

Patients told us they found it difficult to get an appointment at the surgery as they could not get through on the phone so often had to attend in person. They said even when they attended the surgery they would have to wait two to three weeks to get an appointment to see the doctor in advance and that it was virtually impossible to get an emergency appointment. The practice manager told us some emergency appointments were available each day but that they would be taken very early.

Comments received from patients showed that patients in urgent need of treatment had often been unable to make appointments on the same day of contacting the practice. One patient we spoke with told us how they needed an urgent appointment for their relative who had learning disabilities but was unable to see to be seen by a GP within two days.

Inadequate

# Are services responsive to people's needs?

(for example, to feedback?)

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for handling all complaints in the practice.

Patients we spoke with were unaware of the process to follow should they wish to make a complaint. We noted there were no leaflets available in the waiting room and there were no signs about how to complain displayed in the practice.

We looked at eight complaints received in the last twelve months and found that six of these were satisfactorily handled in a timely way. Minutes of team meetings showed that some complaints were discussed, to ensure all staff were able to learn and contribute. However, lessons learnt from individual complaints had not been acted upon. For example we saw patients had complained in April 2014 about the delay in sending medical records when they had de-registered, but the practice had not yet implemented a system to ensure this would happen in a timely way. We saw that bags containing ex-patient records had been placed in the converted loft of the practice. We asked the administration staff if they were aware of what was in the loft and whether they had a system to locate records in a timely way if needed. They told us there was no system and they would have to look through the bags until the records were located.

# Are services well-led?

Inadequate

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

## Our findings

### Vision and Strategy

The practice did not have a clear vision to deliver high quality care and promote good outcomes for patients. We found they had a statement of purpose which stated their aim was to build and maintain personal meaningful relationships with all patients allowing time for comprehensive, thorough and accurate personal health assessments. However, we spoke with six members of staff and they were not aware of the statement of purpose or any vision and values for the practice.

### Governance Arrangements

The practice did not have any clear governance arrangements in place. The registered manager did not understand their responsibilities in relation to managing the practice. They had been away from the practice for extended periods over the past year and had not clearly delegated their responsibilities to anyone at the practice. Staff we spoke with were not clear who they should approach when they needed guidance for areas of their work or if there were concerns.They said they would either contact the practice manager or the office manager.The practice manager would lead the practice meetings. We saw notes from these meetings.Areas discussed included referrals, home visits and administration concerns.

There was no evidence that the practice used the Quality and Outcomes Framework (QOF) to measure their performance.We were told QOF data was discussed at practice meetings and staff told us they had been asked to book appointments for patients on QOF register but did not know who these patients were. Action plans had not been produced to maintain or improve outcomes.

The practice did not have any systems in place to monitor and manage risk.

### Leadership, openness and transparency

The practice did not have a clear leadership structure which had named members of staff in lead roles.Staff were not clear about who the lead was for all areas such as infection control and safeguarding. We spoke with six members of staff none of whom were clear about their own roles and responsibilities.They all told us they did not feel valued or supported.

We saw from minutes that team meetings were held at least every six weeks. Staff told us they did not feel confident to raise issues at team meetings. We also noted that team away days were not held.

The practice manager was responsible for policies and procedures and we saw that they were kept in a file in their office. Staff we spoke with did not know where to find these policies if required.

We reviewed the recruitment and selection policy and found the practice was not following their own procedure. For example, the policy stated that all members of staff would be given a written job description and that references would be sought prior to employment. The practice manager and the reception staff told us they did not have job descriptions and we found that there were no references on file for some members of staff.

### Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. The practice manager showed us the analysis of the last patient survey, which had a common theme of access to appointments and not being able to contact the surgery by phone. However, the practice was unable to demonstrate any improvements they had made as a result of feedback.

There were no processes in place to gather feedback from staff.

### Management lead through learning & improvement

We looked at staff files and saw that regular appraisals did not take place. Staff told us that the practice did not support them to attend training and that they did not have staff away days.

The practice had not shared with staff any completed reviews of significant events or other incidents.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br>**The registered person did not have effective systems in place to regularly assess and monitor the quality of the service provided or to identify, assess and manage risks relating to the health, welfare and safety of the patients or others attending the practice.**<br>**Regulation 10 (1) (a) (b).** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse<br>**The registered person did not make suitable arrangements to ensure patients were safeguarded against the risk of abuse by taking reasonable steps to identify the possibility of abuse and prevent it before it occurred.**<br>**Regulation 11(1)(a)** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>**Patients were not protected against the risks associated with unsafe use and management of medicines.**<br>**Regulation 13** |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Compliance actions

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment<br>The registered person did not make suitable arrangements to protect patients and others from the use of unsafe equipment by ensuring that equipment is properly maintained and suitable for its purpose.<br>Regulation 16(1)(a) |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br>The registered person did not make suitable arrangements to ensure that patients were enabled to make or participate in making decisions relating to their care or treatment.<br>Regulation 17(1)(b)(2)(c)(I)(ii) |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers<br>The registered person did not operate an effective recruitment procedure in order to ensure that no person was employed that was of good character or had the qualifications, skills and experience for their role.<br>Regulation 21(a)(i)(ii) |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br>The registered person did not have suitable arrangements in place to ensure staff were appropriately supported in relation to their responsibilities to ensure they deliver care and treatment to an appropriate standard by receiving appropriate training, supervision, appraisals and professional development. |

This section is primarily information for the provider

# Compliance actions

Regulation 23(1)(a)(b)