Dr Paramjit Wasu

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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall. (Previous inspection October 2015 – Requires Improvement)

The key questions are rated as:

Are services safe? - Inadequate

Are services effective? – Requires Improvement

Are services caring? - Good

Are services responsive? - Good

Are services well-led? - Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The concerns raised in Safe and Well Led affect all of the population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

People experiencing poor mental health (including people with dementia) - Inadequate

We carried out an announced comprehensive inspection at Dr Paramjit Wasu on 7 October 2015. We found breaches of the legal requirements and as a result we issued requirement notices in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 - Good Governance.

The practice was rated as good for providing caring and responsive services and requires improvement for providing safe, effective and well-led services. Overall the practice was rated as requires improvement.

The full comprehensive report on the October 2015 inspection can be found by selecting the 'all reports' link for Dr Paramjit Wasu on our website at www.cqc.org.uk.

We carried out a comprehensive inspection of this service, on 7 December 2017, 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 was 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 Act.

During the inspection we found that the practice had not responded fully to the concerns raised during the October 2015 inspection. We also found other breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for the practice is now inadequate.

At this inspection we found:

Summary of findings

- There was not a transparent approach to safety. The system for learning from significant events was not effective.
- Searches were not being routinely undertaken to identify patients who may be at risk as a result of Medicine and Healthcare products Regulatory Agency (MHRA) alerts.
- The arrangements for managing medicines in the practice did not always keep patients safe. We found controlled drugs with no recording system and out of date medications.
- The practice did not have adequate arrangements to respond to emergencies.
- The practice assessed patients' needs but was unable to demonstrate they always delivered care in line with current evidence based guidance.
- The practice was unable to demonstrate that clinical audits were driving quality improvements.
- Not all chaperones were trained, DBS checked or risk assessed as to their suitability to the role.
- There were no systems in place to mange prescription security and rooms were routinely left insecure.
- Not all staff had received training in health and safety, infection control, equality and diversity or other mandatory training.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Governance arrangements were not always effectively implemented.
- The practice was unable to demonstrate they had an effective action plan to improve performance.
- There was a leadership structure and staff felt supported by management.
- The practice was unable to demonstrate their management of record keeping was always effective and complete.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- 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.
- Carry out clinical audits and re-audits to drive quality improvement and improved patient outcomes.
- Dispose of controlled drugs in an appropriate manner or implement the approved methods for securing and recording them.

The areas where the provider **should** make improvements are:

- Carry out Disclosure and Barring Service (DBS) checks, or risk assessments, for all staff who act as chaperones.
- Carry out regular, documented checks of all emergency medication and equipment.
- Identify and keep a record of patients who are carers to help ensure they are offered appropriate support.
- Ensure verbal complaints are recorded and actions monitored.

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

Dr Paramjit Wasu

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Dr Paramjit Wasu

The practice is a single location surgery which provides a primary medical service through a General Medical Services (GMS) contract. The practice is based in a residential area within Harrow, in north west London, part of Harrow CCG.

The practice is based in a house that has been modified and is accessible to people with mobility needs on the ground floor. Consultation and treatments are provided across the ground and first floor, which is only accessible by stairs.

The population groups served by the practice included a cross-section of socio-economic and ethnic groups. A relatively low proportion of patients (4.8% of the practice population) were aged over 75. There were also below average numbers of children under 4 (3.9% of the practice population), for under 18s it was higher at 19.5%.

The practice is registered to carry on the following regulated activities: Diagnostic and screening procedures; Family planning; Treatment of disease, disorder or injury; and Surgical procedures. At the time of our inspection there was one GP (male) who does nine sessions per week, one locum GP (female) who does four sessions per week and a practice manager (female). There was also practice nurse (female), a health care assistant/phlebotomist (female) and three admin/reception staff in post.

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 9.00am to 12pm every morning and 4pm to 6pm daily. Extended hours surgeries were offered on Monday and Friday from 6.30pm to 7.30pm. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

During January 2015 NHS England terminated the contract with Dr Paramjit Wasu's practice, due to insolvency issues. The patient list was reallocated to other local practices. In July 2015 the practice reopened and during the inspection we were told that the patient list was now 2,558. Prior to closure of the practice the list size was 3,532.

We carried out an announced comprehensive inspection at Dr Paramjit Wasu on 7 October 2015. We found breaches of the legal requirements and as a result we issued requirement notices in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 - Good Governance.

The practice was rated as good for providing caring and responsive services and requires improvement for providing safe, effective and well-led services. Overall the practice was rated as requires improvement following the October 2015 inspection.

The full comprehensive report on the October 2015 inspection can be found by selecting the 'all reports' link for Dr Paramjit Wasu on our website at www.cqc.org.uk.

Inadequate

Are services safe?

Our findings

We rated the practice, and all of the population groups, as inadequate for providing safe services.

At our previous inspection on 7 October 2015, we rated the practice as requires improvement for providing safe services at that time:

- The practice was unable to demonstrate that significant events and incidents were monitored, reviewed and appropriately addressed.
- The practice was unable to demonstrate that action had been taken as a result of recommendations in an infection control audit.
- The practice did not have a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

The practice had addressed some of these issues when we undertook a comprehensive inspection on 7 December 2017. However, at this latest inspection we also found evidence of other breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The practice is now rated as inadequate for providing safe services.

Safety systems and processes

The practice did not have effective systems in place to keep patients safe and safeguarded from abuse.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- Staff demonstrated that they understood their responsibilities but not all staff had received training on safeguarding children and vulnerable adults relevant to their role. From documentation provided, we could see no evidence of child safeguarding training for two of the reception/admin staff and no evidence of adult safeguarding training for several clinical and non-clinical staff. We saw no evidence that the locum GP had received any training in the safeguarding of adults or children.
- A notice in the waiting room advised patients that chaperones were available if required. Not all staff who acted as chaperones were trained for the role or had 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).
- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead. However, the practice was unable to demonstrate they liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol. The practice was unable to provide records to demonstrate that all relevant staff had received up to date infection prevention and control training. The practice was also unable to provide any documentary evidence to show that annual infection control audits were undertaken.
- We found that some sharps bins were not signed, labelled or dated in accordance with regulations.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Although the legionella risk assessment carried out in June 2017 recommended regular monitoring of water temperatures and water sampling, this had not been carried out.

Inadequate

Are services safe?

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.
- 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. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Not all of the medicines we checked were in date and stored securely.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Information to deliver safe care and treatment

Staff told us that they had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were not securely stored and there were no systems to monitor their use. We found blank prescription pads left in, and on top of, printers in unlocked rooms and spare blank pads in an unlocked cupboard.
- Patient Group Directions had been adopted by the practice to allow the nurse to administer medicines in line with legislation. The health care assistant was trained to administer vaccines and medicines and patient specific directions from a prescriber were produced appropriately.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) but had no procedures to manage them safely. There was no secure storage or register. We found nine ampoules of Morphine and nine ampoules of Midazolam (both in date) plus some oral diazepam which had expired in September 2017. When questioned about the disposal of controlled drugs, the GP did not appear to be aware of regulations surrounding safe disposal. There was no policy which set out how controlled drugs were to be stored, recorded or disposed of.
- The arrangements for storing emergency medicines and equipment required review to ensure that these were secure. Rooms where these items were stored were not routinely locked.
- Regular checks were not taking place on emergency equipment or medications. There had been no documented checks on the emergency medications, oxygen or defibrillator since April 2017. We were told that this was due to the practice nurse being on maternity leave. At the commencement of the inspection we noticed that the oxygen cylinder was showing as being under half full. We were told that this was because it had been used the day previously and that a new cylinder was on order. We subsequently found out that an ambulance had been called for a patient in November 2017 and it was then that the oxygen had been used.
- We found a large number of medications/vaccines, dressings, syringes and needles which were out of date but still in vaccine fridges or other areas ready for use. We also found out of date first aid kits and biohazard spill kits.

Inadequate

Are services safe?

Track record on safety

The practice took steps to maintain the safety of the environment.

- There was a health and safety policy available and a recent health and safety risk assessment had been carried out. One of the recommendations was for the first aid kit to be replaced with one that was in date. This had not been done at the time of our inspection.
- The practice had an up to date fire risk assessment and we were told that the practice had carried out a fire drill in February 2017, although this wasn't documented in a log. There were no designated fire marshals within the practice.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Although the legionella risk assessment carried out in June 2017 recommended regular monitoring of water temperatures and water sampling, this had not been carried out.

Lessons learned and improvements made

We were not assured that the practice learnt from, or made significant improvements, when things went wrong.

- We could not see an effective system for reporting and recording significant events. There appeared to be uncertainty as to what constituted a significant event and action taken from significant events was not always clear or effective. Staff told us they would inform the practice manager of any incidents and although there was a form available it did not appear to be routinely used.
- The incident recording form supported the recording of notifiable incidents under 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). We were told of an example where the duty of candour was followed when a patient, who was allergic to penicillin, was prescribed it. On becoming aware of the error the GP apologised but this was not recorded as a significant event and so no learning outcomes were recorded or disseminated to other staff.
- The system to act on Medicine and Healthcare products Regulatory Agency (MHRA) alerts was not effective. The practice manager received some alerts and, if considered relevant, passed them on to clinical staff. These alerts were not being recorded on a log and there was no evidence of either searches being routinely undertaken to identify patients at risk or follow up to see whether the alert had been dealt with.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as requires improvement for providing effective services overall and inadequate across all population groups.

At our previous inspection on 7 October 2015, we had rated the practice as requires improvement for providing effective services, as:

- There was limited evidence that clinical audits were driving quality improvement.

These arrangements had not improved sufficiently when we undertook a follow up inspection on 7 December 2017.

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The total number of prescribed antibiotic items per 1000 registered patients by quarter was comparable to the national average (practice 1.61; national 0.9). The percentage of broad spectrum prescribed antibiotic items (cephalosporin, quinolone and co-amoxiclav class) by quarter was also comparable to the national average (practice 7.18% national 4.71%). The practice told us they were working with the medicine optimisation team and attended locality prescribing group meetings which was a forum to share good practice with other practices.

Older people:

The practice had a dedicated care co-ordinator who made sure that:

- older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication with a GP.
- patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- the practice followed up on older patients discharged from hospital and ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met.
- This practice was not an outlier for any QOF (or other national) clinical targets.

Families, children and young people:

- Appointments were available outside of school hours and the premises were suitable for children and babies.
- There were baby changing facilities available in the practice.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 74%, which was in line with the 80% coverage target for the national screening programme.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and Saturday appointments.
- 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia):

- 95% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable to the national average.
- 73% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 97%; CCG 92%; national 91%) and smoking cessation (practice 96%; CCG 96%; national 95%) were comparable to local and national averages.

Monitoring care and treatment

The most recent published Quality Outcome Framework (QOF) results were 96% of the total number of points available compared with the clinical commissioning group (CCG) and national averages of 95%. The overall exception reporting rate of 10% was comparable to the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2016-2017 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example, 76% of the practice's patients with diabetes, on the register, whose last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months compared with the local CCG and national averages of 80%. 78% of the practice's patients with diabetes, on the register, had a last measured total cholesterol of 5mmol/l or less compared with the local CCG average of 81% and national average of 80%.
- Performance for asthma related indicators was higher than the local CCG and national average. For example, 86% of patients with asthma, on the register, had had an asthma review in the preceding 12 months that included an assessment of asthma control using the three RCP questions compared with the local CCG average of 77% and the national average of 76%.
- Performance for mental health related indicators was lower than the local CCG average and national average. For example, 73% of the practice's patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their records in the preceding 12 months, compared with the local CCG average of 91% and national average of 90%. The GP was unclear as to why the numbers were so low.

There was limited evidence of quality improvement including clinical audit:

Requires improvement

Are services effective?

(for example, treatment is effective)

- There had been two clinical audits commenced in the last two years with neither of them being taken to a second cycle so as to drive clinical improvement. One was a minor surgrey audit which recorded the numbers and types of procedures carried out whilst the other was a urine analysis audit in children aged 0-5 years, which reviewed if urine analysis requests can help diagnose other conditions which were unknown/or not apparent via consultation alone.

Effective staffing

Evidence reviewed showed that not all staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality but not all staff had received training as recommended.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. However there were no training records for the long term locum GP.
- Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work but records showed that not all staff were up to date with training in chaperoning, safeguarding vulnerable adults, safeguarding children, infection prevention and control, equality and diversity, information governance, and fire safety.

Coordinating care and treatment

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.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

Information was shared between services, with patients' consent, using a shared care record.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping 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:

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The practice's uptake for the cervical screening programme was 74%, which was comparable with the CCG average of 77% and the national average of 81%.

Childhood immunisations were carried out in line with the national childhood vaccination programme but we were unable to obtain recent data due to the 2015 closure and subsequent re-opening of the practice.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems 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.

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.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice as good for providing caring services overall and inadequate across all population groups.

At our previous inspection on 7 October 2015, we rated the practice as good for providing caring services.

The practice is still rated as good for providing caring services.

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Kindness, respect and compassion

During our inspection we observed that members of staff were courteous and very 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.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced, Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two patients who both told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. For example:

- 90% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 86%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 86%.

- 89% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 91%.
- 88% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 94% of patients said they had confidence and trust in the last nurse they saw compared with the CCG and national averages of 95%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 89% of patients said they found the receptionists at the practice helpful compared with the CCG average of 84% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. For example, the managers of some of the local care homes where some of the practice's patients lived all praised the care provided by the practice. Each care home had allocated visits by the GP each week.

Good

Are services caring?

Involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments which compared with the CCG and national averages of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 86% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 90%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the 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. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice could not give us an accurate number of patients that they had identified as carers as, due to confusion as to the definition of a carer, the practice manager had been recording patients who had a carer rather than those who were carers. The practice agreed to review this but we have not been given any accurate figures as to the number of carers registered at the practice.

Staff told us that if families had experienced bereavement, the GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice as good for providing responsive services overall and inadequate across all population groups.

At our previous inspection on 7 October 2015, we rated the practice as good for providing responsive services.

The practice is still rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice offered late evening appointments on Monday and Friday and was also open on Saturday morning.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from two examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

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:

- The practice offered extended hours on a Monday and Friday evening until 7.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as some which were only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Disabled facilities, including a toilet were available on the first floor. The front door was automatic and push button operated.
- There was a touch screen next to the reception so that patients could check themselves in, and a screen in the waiting area which announced the doctor being ready for the patient's appointment.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

The practice was open between 8:30am and 6:30pm Monday, Tuesday, Thursday and Friday. Appointments were from 9:00am to 12:00pm every morning and from 4:00pm to 6:00pm every afternoon with the exception of Wednesday when the practice closed at 1:30pm. Extended hours appointments were offered between 6:30pm and 7:30pm on Monday and Friday and between 10:30am and 12:30pm on Saturday. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for patients that needed them.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. Three hundred and sixty eight surveys were sent out and 96 were returned. This represented about 4% of the practice population.

- 86% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 85% of patients who responded said they could get through easily to the practice by phone; CCG – 64%; national average - 71%.
- 80% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 80%; national average - 84%.
- 89% of patients who responded said their last appointment was convenient; CCG - 73%; national average - 81%.
- 86% of patients who responded described their experience of making an appointment as good; CCG - 67%; national average - 73%.
- 56% of patients who responded said they don't normally have to wait too long to be seen; CCG - 44%; national average - 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance.
- We looked at one written complaint received in the last 12 months and found that it had been investigated and the complainant had received a response. The practice was unable to demonstrate that verbal complaints were investigated. Staff told us that verbal complaints received were not recorded and were dealt with by discussion only. The practice was also unable to demonstrate they had learned from the verbal complaints or had implemented appropriate changes.

Are services well-led?

Inadequate

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

Our findings

We rated the practice, and all of the population groups, as inadequate for providing a well-led service.

At our previous inspection on 7 October 2015, we rated the practice as requires improvement for providing well-led services because at that time:.

- The practice had a number of policies and procedures to govern activity, but some of these were overdue a review to ensure the most recent policies were being used.
- There was a lack of oversight in risk assessment and records to evidence what had been done in the practice.

The practice was able to demonstrate they had addressed some of these issues when we undertook a comprehensive inspection on 7 December 2017. However, we also found evidence of other breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The practice is now rated as inadequate for providing safe services because:

- The practice was unable to demonstrate they had an effective system for the management of medicines.
- The practice had a vision to deliver high quality care and promote good outcomes for patients. However, most of the staff we spoke with were not aware of the practice's vision or statement of purpose.
- Governance arrangements were not always effectively implemented because there was a lack of awareness and understanding of governance requirements from the GP and practice manager. For instance there was no system to help ensure all governance documents were kept up to date and records of significant event management and complaints management were not always complete.
- There were no regular clinical meetings where information such as MHRA alerts, patients of concern, NICE guidelines and significant events and complaints were considered or cascaded.
- The practice had failed to assess and manage in an effective and timely manner all identified risks to patients, staff and visitors.

Leadership capacity and capability

The principal GP did not have the necessary experience, knowledge, capacity and skills to lead effectively.

- The principal GP was not always aware of the risks and issues within the practice.
- The principal GP was visible and approachable and worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The GP had a clear vision to deliver high quality care and promote good outcomes for patients,but the fragmented nature of the leadership of the practice impacted upon the practice's ability to deliver that vision.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.

Culture

On the day of inspection the GP told us they prioritised high quality and compassionate care.

- Staff told us the GP was approachable and always took the time to listen to all members of staff.
- The provider was aware of and complied 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). From one example we reviewed we found that the practice gave the affected person reasonable support, truthful information and a verbal apology. However, the practice did not keep written records of verbal interactions.
- Lack of effective oversight of risk, leadership and governance generally put staff at risk; particularly in respect of medicines management and checking of equipment.

Governance arrangements

There was a lack of clarity around key areas of responsibility and accountability. Governance systems did not operate effectively. Policies lacked clarity, were not practice specific and contained inaccurate information.

- There was a staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. The GP, for example was the Caldicott Guardian and lead for safeguarding whilst the practice nurse was the infection control lead.
- Practice policies were implemented and were available to all staff. However, these still needed updating and personalising to the practice as it now was. Since the

Are services well-led?

Inadequate

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

closure and subsequent re-opening, the practice was now known to patients as "First Choice Medical Care" but many of the policies referred to either Wasu Medical Centre or RJW Healthcare Ltd. There were also references to the PCT (Primary Care Trust) which ceased in 2013 rather than the CCG (Clinical Commissioning Group). Wasu Medical Centre was the previous trading name of the practice whilst RJW Healthcare refers to the new legal entity and contract holder.

- Both the GP and the practice manager prioritised high quality and compassionate patient care and all of the GPs time and attention was concentrated in this area, leading to a lack of understanding of the practical management of the practice or compliance with recommended practice and statutory requirements.
- The GP was visible in the practice and staff told us that he was approachable and always took the time to listen to all members of staff.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, the practice was unable to demonstrate they had an effective system for the management of medicines, with many medicines/ vaccines, dressings, etc. being out of date, and controlled drugs not being safely stored and recorded.
- The practice had failed to assess and manage in an effective and timely manner all identified risks to patients, staff and visitors. For example, infection control risks, fire safety risks, risks from substances hazardous to health and the potential risk of legionella in the building's water system.
- Practice meetings were held bi-monthly which provided an opportunity for staff to learn about the performance of the practice.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- All staff we spoke with were aware of the business continuity plan and were aware of how to manage major incidents and summon help in an emergency. However, we did not see evidence of up to date fire training for a number of staff.
- The practice had basic processes to manage current and future performance.
- Practice leaders had oversight of incidents, and complaints, but the practice did not have effective systems that identified and recorded outcomes of Medicines and Healthcare products Regulatory Agency (MHRA) alerts.
- There was still limited evidence that clinical audits, or any other activity, was driving quality improvement.
- The practice could not demonstrate processes to manage the performance of its clinical staff, for example, through audit of their consultations, prescribing and referral decisions.

Appropriate and accurate information

The practice generally acted on appropriate and accurate information.

- In most cases, quality and operational information was used to ensure and improve performance. However, we saw that significant events were not always discussed with staff at the next available meeting and we were not assured that learning from these events had taken place or was disseminated to the staff team.
- Performance information was combined with the views of patients.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice did not always submit data or notifications to external organisations as required. For example the IG Toolkit (required to be submitted by 31st March each year) had not been completed since 2015. IG Toolkit assessments must be completed and published by all bodies that process personal confidential data of citizens who access health and adult social care services.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Are services well-led?

Inadequate

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

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- There was a virtual (on-line) patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of some learning and some improvement within the practice but:

- Records of significant event management and complaints management were not always complete.
- There were limited opportunities for learning both internally and externally which was partially due to the lack of effective systems for sharing information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had not adequately assessed the risks to the health and safety of patients and done all that was reasonably practicable to mitigate any such risks: • The practice did not have systems in place to carry out a thorough analysis of the significant events to identify any themes and take appropriate action. • Not all staff had received Infection control training. • The practice did not carry out the recommendations of their legionella risk assessment. • The practice did not have appropriate emergency medication available in line with published guidance and had not risk assessed the reason not to. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not have effective systems and processes in place to ensure that there was adequate governance oversight of the running of the practice. In particular: • There was no vision or strategy in place for the practice to deliver high quality care, which was shared with all staff to ensure they understood their responsibilities in relation to it.

This section is primarily information for the provider

Requirement notices

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

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider was failing to ensure that care and treatment was provided in a safe way for patients. In particular: • Patient safety alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were not acted on • Patients on high risk medicines were not reviewed appropriately • Prescription pads were not stored securely • Some medicines, vaccines, dressings, syringes and needles were out of date. • First aid and biohazard spill kits were out of date. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were governance systems and processes in place however these were not always effective and compliant with the requirements of the fundamental standards of care. In particular: • There was limited evidence of quality improvement including clinical audit in place to monitor quality and make improvements. • Controlled drugs were not secured and recorded in an appropriate manner

This section is primarily information for the provider

Enforcement actions

- The provider had not ensured the provision of the appropriate support, training, professional development, supervision and appraisal necessary to enable staff to carry out their duties.
- Adequate processes were not in place to check medicines are within their expiry dates

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