Dr Jaswant Rathore

Quality Report

Castle Meadows Surgery
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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	Requires improvement
Are services safe?	**Requires improvement**
Are services well-led?	**Requires improvement**

Key findings

Contents

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Dr Jaswant Rathore on 21 July 2015. The overall rating for the practice was good, however the rating for providing safe services was requires improvement. This was due to the lack of assessment for emergency equipment required and for incomplete recruitment checks on staff acting as a chaperone. The full comprehensive report on the 21 July 2015 and the follow up report on 4 October 2016 inspection can be found by selecting the 'all reports' link for Dr Jaswant Rathore on our website at www.cqc.org.uk.

Following the comprehensive inspection on 21 July 2015, we carried out a focused desk based inspection on 4 October 2016 to confirm that the practice had carried out their plan to meet the requirements identified in our comprehensive inspection on 21 July 2015. We continued to rate the practice Good overall and the rating for providing safe services had improved to Good.

We carried out an announced focused inspection on 6 February 2018 to review the arrangements for providing safe and well-led services following the conviction of Dr Jaswant Rathore on 17 January 2018 and the custodial sentence imposed on 18th January 2018.

Overall the practice is now rated as requires improvement.

Our key findings were as follows:

- The reporting and recording of significant events detailed concerns identified and were appropriately followed up to prevent further occurrences and ensure improvements made where appropriate.
- Arrangements were in place for sharing external best practice guidance and the learning outcomes from significant events, incidents and near misses with staff.
- The practice had systems to keep patients safe and safeguarded from the risk of abuse however, the safeguarding policy for vulnerable adults did not reflect the most up to date guidance.
- The practice had a child protection register and alerts were placed on the clinical system to identify children at risk. A protocol was in place to monitor and follow up children who did not attend hospital appointments. Vulnerable adults were highlighted on the clinical system.
- Infection control audits and action plans had been completed to promote a clean and appropriate environment.
- Staff recruitment checks did not meet legal requirements.
- Staff had clear roles and responsibilities but not all staff had received role specific training.

Summary of findings

- The practice had started to improve their governance arrangements; however there were gaps in the practice's governance systems and processes.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure specified information is available regarding each person employed.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

For details, please refer to the requirement notices at the end of this report.

The areas where the provider should make improvements are:

- Ensure the safeguarding policy for vulnerable adults reflects current guidance on the categories or definitions of the types of abuse for example, modern slavery.
- Provide patients with information of the chaperone service on the practice website and review the practice chaperone policy.
- Introduce an attendance register for staff.

The service will be re-inspected within 12 months of the registration being updated.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people	**Requires improvement**
People with long term conditions	**Requires improvement**
Families, children and young people	**Requires improvement**
Working age people (including those recently retired and students)	**Requires improvement**
People whose circumstances may make them vulnerable	**Requires improvement**
People experiencing poor mental health (including people with dementia)	**Requires improvement**

Dr Jaswant Rathore

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a second CQC inspector.

Background to Dr Jaswant Rathore

Dr Jaswant Rathore is registered with the Care Quality Commission (CQC) as a single-handed provider and is located in the town of Dudley. The practice is also known as Castle Meadow Surgery and the provider holds a General Medical Services contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice is a member of the NHS Dudley Clinical Commissioning Group (CCG). The CCG confirmed that the GMS contract is with three partners at the practice and the CQC registration was in the process of being updated at the time of the inspection.

The practice is situated in a purpose built single storey premises owned by Dr Rathore. The practice provides one treatment room and four consulting rooms. The practice has limited car parking facilities available with allocated spaces and access for those patients with a disability.

The practice staffing comprises:

- One full-time GP partner (female).
- Three salaried GPs (female) working a combined total of 17 sessions per week (plus locum GPs providing cover for maternity leave).
- One GP registrar (male) working five sessions per week.
- Two practice nurses working a combined number of sessions equal to one whole time equivalent (WTE).
- A practice managing partner.
- A practice manager for information technology, health and safety and governance.
- An assistant practice manager.
- A medical secretary.
- A team of five reception staff and an apprentice.

At the time of the inspection the practice had 5,894 registered patients. The practice area has overall average levels of deprivation when compared with local and national averages with pockets of deprivation. The population distribution is broadly in line with local and national averages.

The practice is open from 8am to 6.30pm each week day. Routine appointments can be booked in person, by telephone or on-line. Home visits are available to patients with complex needs or who are unable to attend the surgery. When the practice is closed patients can access the out of hours service provided by Malling Health by calling 111 and there is an urgent care centre at Russells Hall Hospital.

Consulting times with a GP are available in the morning from 8am to 11.30am each week day. Afternoon appointments are available from 2.30pm to 6.30pm on Mondays and Wednesdays and from 4pm to 6.30pm on Tuesdays, Thursdays and Fridays. The nearest hospital with an A&E unit and a walk in service is Russells Hall Hospital.

Further details about the practice can be found by accessing the practice's website at www.castlemeadowssurgery.nhs.uk

Detailed findings

Why we carried out this inspection

We undertook an announced comprehensive inspection at Dr Jaswant Rathore on 21 July 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as overall good; however the rating for providing safe services was requires improvement. The full comprehensive report on the 21 July 2015 inspection can be found by selecting the 'all reports' link for Dr Jaswant Rathore on our website at www.cqc.org.uk.

Following the comprehensive inspection on 21 July 2015, we carried out a focused desk based inspection on 4 October 2016 to confirm that the practice had carried out their plan to meet the requirements identified in our comprehensive inspection on 21 July 2015. We continued to rate the practice overall as good and the rating for providing safe services had improved to good. The follow up report on the 4 October 2016 inspection can be found by selecting the 'all reports' link for Dr Jaswant Rathore on our website at www.cqc.org.uk.

We carried out an announced focused inspection on 6 February 2018 to review the arrangements for providing safe and well-led services following the conviction of Dr Jaswant Rathore on 17 January 2018 and custodial sentence imposed on 18th January 2018.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 4 October 2016, we rated the practice as good for providing safe services.

These arrangements had deteriorated when we undertook a follow up inspection on 6 February 2018. The practice is now rated as requires improvement for providing safe services overall and across all population groups.

The practice was rated as requires improvement for providing safe services because:

- The safeguarding policy for vulnerable adults did not reflect updated categories or definitions of the types of abuse for example, modern slavery.
- The health and safety arrangements did not minimise potential risks to patients, staff and visitors.
- Staff recruitment checks did not meet legal requirements.
- A legionella risk assessment had not been completed.
- The system to check that the emergency medicines and equipment was not effective and the practice had not formally assessed which medicines may be required to deal with an emergency.
- The system for receiving, recording and acting on external safety alerts such as those from the Medicines and Healthcare products Regulatory Agency (MHRA) was not effective

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to all staff. Staff knew how to identify and report safeguarding concerns and had access to internal leads and contacts for external safeguarding agencies. Staff shared examples of reporting safeguarding concerns and worked with other agencies to support patients and protect them from neglect and abuse. However, the vulnerable adults safeguarding policy did not reflect updated categories or definitions of the types of abuse such as modern slavery or female genital mutilation (FGM).
- The practice had a range of safety policies in place which were communicated to staff. There were systems in place for identifying, assessing and mitigating some risks to the health and safety of patients and staff and records of safety checks undertaken. However, we identified shortfalls in how risk was managed and not all environmental risks to patients and staff had been formally assessed and effectively monitored. For example:

- The fire risk assessment had not been reviewed since January 2012.
- A general risk assessment of the building had not been carried out to identify risks; for example; the practice had blinds with pull cords in most rooms but had not assessed the risk.
- There was no evidence that the fixed wire testing had been carried out.
- A legionella risk assessment had not been completed.

- We saw the practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). However, we found shortfalls in the recruitment checks of the three staff files we reviewed. For example:

- There were no assessments of physical or mental health conditions of staff members which were relevant to the person's capability, after reasonable adjustments were made, to carry out their role.
- DBS checks carried out on the three staff members had been completed by previous employers and there was no process in place to check if these were still current.
- There was no record of any references having been obtained for one staff member.

- Clinical and administration staff acted as chaperones. They were trained for the role and had received a DBS check. There was a chaperone policy in place and we saw this had recently been reviewed and was due to be further updated to state that no intimate examinations were to be carried out without the presence of a chaperone. Notices were displayed in consultation and clinical rooms advising patients that chaperones were available if required. However, patients were not advised of their right to request a chaperone on the practice website. Staff we spoke with had the

knowledge of what to do when acting as a chaperone. However, they did not always record on patients' electronic records that a chaperone was present during an intimate examination.
- Staff had received up-to-date safety training or safeguarding training appropriate to their role.
- There was a system to manage infection prevention and control (IPC). There was a designated infection prevention and control clinical lead in place. An IPC audit was carried out every three years by external auditors and each year by the practice IPC lead.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. Rotas were produced for GPs, nurses and reception staff.
- There was an effective induction system for temporary staff tailored to their role. For example, we saw checklists in place for locum staff that included checks made against their registration status, qualifications and training records. An induction pack was available and included fire procedures, external agency numbers, the appointment system, internal procedures, workflow information, staff team members and roles.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. For example, a GP going on maternity leave.
- The practice had a business continuity plan with up to date contact numbers. Copies were kept off site. The plan required a review to update the current staff contact details.

Information to deliver safe care and treatment

Staff 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.
- The practice used a directory of local guidelines to facilitate referrals along accepted pathways. This provided comprehensive, evidenced based local guidance and clinical decision support at the point of care and was effective in reducing referrals.

Safe and appropriate use of medicines

The practice had some systems for appropriate and safe handling of medicines.

- The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. For example, changes in medicines following test results, hospital discharges and clinics held for long term conditions.
- Patients on high risk medicines were managed appropriately. We checked three patients on a high risk medicine used to treat rheumatoid arthritis and all had up to date blood test monitoring.

Emergency medicines were held to treat a range of sudden illnesses that may occur within a general practice and during GP home visits. Staff we spoke with knew of their location. However, there was not an effective system in place for managing the emergency medicines and equipment as some of the emergency medicines had run out and were on order. The range of suggested emergency medicines that GP practices need for use in acute situations was last updated in October 2017. The practice was not aware that additional medicines had been added and therefore had not obtained all of the suggested medicines or completed a formal risk assessment to

demonstrate how risks to patients would be mitigated in the absence of suggested emergency medicines. The practice had a defibrillator but had not checked it since July 2017 and there were no pads for use on children.

Track record on safety

The practice arrangements for managing the health and safety of the patients, staff and visitors required further strengthening:

- There were risk assessments in relation to safety issues in place and records of routine safety checks undertaken. However, there was no general assessment of risks identified.
- There was no evidence that a hard wire test, a legionella risk assessment and an asbestos survey had been carried out on the building (a legionella risk assessment had been booked for 24th February 2018).
- A health and safety lead had recently been appointed and training specific to their role was planned.
- There was a visitor's book but no attendance log for staff.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, there was no clear system to demonstrate how the practice used external safety alerts to make improvements.

- There was a system and procedure for recording and acting on significant events and incidents. There was a standard recording form available on the practice's computer system. Staff we spoke with told us they were encouraged to raise concerns and report incidents and near misses and demonstrated an understanding of the procedure. The practice planned to reintroduce dedicated meetings to review action taken and share learning with the wider practice team.
- The system in place to act on external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety was not effective. The practice manager and GP received safety alerts. However, they could not demonstrate how alerts appropriate to the practice had been acted on or incorporated into clinical practice. For example, the GP we spoke with was aware of an alert regarding the use of an anticonvulsant medicine and its prescribing to pregnant women of child bearing age. Patients at risk had been identified, however, there was no documentary evidence these patients had been reviewed as the action taken was not recorded in the patients' records.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 4 October 2016, we rated the practice as good for providing well-led services.

These arrangements had deteriorated when we undertook a follow up inspection on 6 February 2018. The practice is now rated as requires improvement for providing well-led services overall and across all population groups.

The practice was rated as requires improvement for providing well-led services because:

- Policies, procedures and activities did not always ensure safety.
- There were gaps in processes for managing risks, issues and performance.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the practice had drawn up an action plan to address immediate priorities. These included administrative tasks such as the need for revising policies and clinical tasks such as improving performance around specific areas of the Dudley Outcomes for Health framework. Dudley CCG is one of four vanguards in England that does not follow the National Quality Outcomes Framework (QOF) but has developed its own outcome framework.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff had lead roles and were aware of their roles and responsibilities. However, training had not always been provided to support individuals in carrying out their specific duties.
- The practice had effective processes to develop leadership capacity and skills by delegating to the wider practice team. For example, the partners were looking to promote a member of staff to manage patient services.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The practice had a formal strategy that was discussed between partners.
- The practice had engaged with the local Clinical Commissioning Group (CCG) to gain support with the significant changes recently experienced. An action plan had been developed to prioritise the workload and resilience funding had been secured to facilitate this.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They told us they felt well-informed and supported with the recent changes. This included a written statement for patients that was available at the practice and on their website.
- The practice focused on the needs of patients and Dudley CCG reported that the practice was a high performing practice within the Dudley Quality Outcomes for Health Framework.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed and had access to a policy in the event of needing to raise concerns in relation to staff practice in the workplace.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff had received annual appraisals and were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for attending various meetings held in addition to professional development and evaluation of their clinical work.

Governance arrangements

Are services well-led?

Requires improvement

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

The provider was in the process of implementing a new governance structure following the change in senior GP.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. Delegation had taken place to extend responsibilities among the practice team, for example; the practice manager had taken the role of health and safety lead.
- Practice leaders had established policies and procedures. However, we saw a number of these required updating and did not always govern activity. For example staff checks were not always completed in accordance with the recruitment policy. The practice planned to phase the programme of updating policies to prioritise those deemed most urgent.
- Policies were accessible to staff but there was no audit trail or document control. The practice told us that they planned to use an electronic system to rectify this.
- Monthly meetings had commenced in January 2018 and an invite extended to all staff. The GPs had regular clinical meetings in conjunction with the multidisciplinary team meetings.
- A dedicated meeting held to discuss significant events and complaints had lapsed. The practice planned to reintroduce these shortly.

Managing risks, issues and performance

The processes for managing risk required strengthening.

- There was no centralised process to identify, understand, monitor and address current and future risks including risks to patient safety. Some environmental health and safety risk assessments had been completed to identify hazards and mitigate potential risks, however there was no risk log and we identified some gaps.
- The practice did not have an effective process to manage external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

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.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The practice had established a patient participation group (PPG) and regular meetings were held.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning and continuous improvement.

- All practice staff we spoke with were receptive to change and determined to make the required improvements within the practice.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- We saw evidence of where the practice monitored and identified areas of improvement in the Dudley Quality Outcomes for Health Framework and the Dudley Long-term Condition (LTC) Programme. For example, the practice were targeting the patients with a long-term condition that were due a review before April 2018.
- We saw staff had been supported with their career progression within the practice. For example, a receptionist had been developed into the assistant practice manager position and another receptionist promoted to medical secretary.

Are services well-led?

Requires improvement

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

- The practice encouraged innovation, for example; a GP registrar had been supported with a project looking at how medical photography could be used for the examination of skin lesions.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** There was no proper and safe management of emergency medicines and equipment. In particular: • A formal system to check that the emergency medicines and equipment was not in place. • A risk assessment had not been completed to demonstrate how risks to patients would be mitigated in the absence of recommended emergency medicines. There was no assessment of the risk of legionella. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.