Dr Hafeez and Partner

Quality Report

181 Carshalton Road
Sutton
Surrey
SM1 4NG
Tel: 020 8661 1505
Website: www.suttonmedicalcentre.nhs.uk

Date of inspection visit: 20 January 2015
Date of publication: 26/03/2015

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

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Dr Hafeez and Partner also known as Sutton Medical Practice is a medium sized practice based in Sutton. The practice has a list size of 4200 patients.

We carried out an announced comprehensive inspection at Sutton Medical Practice on 20 January 2015 .Overall the practice is rated as inadequate.

We found numerous issues in relation to the safe delivery of patient care. There were inadequate systems in place to monitor and respond to risks. The extent of the issues identified indicated that there was a lack of systems to adequately manage the service. For the key questions of whether the practice provided a, safe, effective and well-led service we rated it as inadequate. We rated responsive and caring as requires improvement.

Due to inadequate ratings in safe, effective and well led .The concerns which led to these ratings apply to all population groups using the practice.

Our key findings across all the areas we inspected were as follows:

- Though staff understood their responsibilities to raise concerns, and report incidents and near misses, safety was not sufficiently prioritised and there were inadequate systems in place to monitor and manage risks.
- Not all incidents and complaints had learning points identified that were acted on and shared with staff. As a result, there were recurring themes in the complaints that were received.
- Patients were at risk of unsafe care as the practice did not have equipment to use in emergencies such as oxygen and an automated external defibrillator and no risk assessments had been carried out.
- Not all staff demonstrated the necessary competencies in relation to safeguarding of vulnerable adults and children and the administrative staff were acting as chaperones without training and a Disclosure and Barring Service check.

Summary of findings

- There was insufficient assurance to demonstrate people received effective care and treatment. For example there was no multi- disciplinary working taking place to improve patient care.
- There were insufficient systems in place to protect patients from the risk of healthcare associated infections.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- The practice had a lack of clear leadership structure and there were limited formal governance arrangements.

The areas where the provider must make improvements are

- Ensure significant events are recorded appropriately and discussed regularly.
- Ensure learning from incidents is identified and shared with all practice staff.
- Ensure a regular review of complaints takes place, learning is identified and issues addressed.
- Ensure the practice has the required medical equipment to respond in an emergency.
- Take action to address identified concerns with healthcare associated infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure formal governance arrangements are in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- The practice must ensure that all clinical and administrative staff are suitably trained, supervised and appraised.
- Ensure that reception staff acting as chaperones have Disclosure and Barring Checks (DBS).

The areas where the provider should make improvement are:

- The practice should also work with other professionals and organisations involved in patients' care to ensure the patients receive care that is well co-ordinated and effective.
- Actively seek to involve patients in developing and improving the service.
- The practice should ensure they have risk assessments in place and are able to justify the reason for not undertaking location specific Disclosure and Barring Service Checks (DBS) checks such as those for temporary staff.
- Ensure a business continuity plan for the practice is in place.
- Ensure patient feedback is obtained pro-actively
- Ensure an up to date whistleblowing policy is in place and staff are aware of how to raise concerns.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services, and improvements must be made.

The practice did not have adequate systems to identify risks and improve patient safety. There was no system to action alerts received from organisations such as the Medicines and Healthcare Regulatory Authority (MHRA). When things went wrong, learning points were not always identified and actioned. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. Administrative staff were not aware of the processes of reporting safeguarding concerns and although they had undertaken training they could not demonstrate the knowledge learnt. No infection control audits were being undertaken.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

The practice did not have a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers. The practice manager and both GPs were not clear about the policy for dealing with blood test results and other diagnostic tests. We found that a blood test result received on 30 December 2014 that required being actioned was left in the inbox of received results without being filed or matched to the patient's records. We also found that another result received on 9 January 2015 had not been acted on.

Staff had knowledge of and reference to National Institute for Health and Care Excellence guidelines but there were no systems to ensure this was implemented consistently. The practice had not completed full cycles of clinical audits. We saw no evidence that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was not taking place. The practice manager and practice nurses had last received appraisals in early 2013.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care

Summary of findings

and treatment. Patient information about the services that were available was readily available and easy to understand. We also saw that staff treated patients with kindness and respect, and maintained patient confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Overall patients were satisfied with the appointments system offered at the practice. However, the practice did not have systems that recognised and implemented changes to meet locally identified needs. Complaints were not being handled appropriately and there was lack of review and learning from complaints.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy of the practice. There was no clear leadership structure. The practice did not have policies and procedures to govern activity. The practice did not hold regular governance meetings. The practice had not proactively sought feedback from staff or patients. Staff told us they had not received regular performance reviews. Those that had completed reviews did not have clear set objectives.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as Inadequate for safe, effective and well led.

The concerns which led to these ratings apply to everyone using the practice, including this population group.

The care of older people was not managed in a holistic way. The leadership of the practice have little understanding of the needs of older people and were not attempting to improve the service for them. Services for older people were therefore reactive, and there was a limited attempt to engage this patient group to improve the service.

People with long term conditions

Inadequate

The provider was rated as Inadequate for safe, effective and well led.

The concerns which led to these ratings apply to everyone using the practice, including this population group.

Very few of these patients had a named GP and personalised care plan. Structured annual reviews were not undertaken to check that patients' health and care needs were being met. Multi-disciplinary team meetings were not held to support and review care of patients.

Families, children and young people

Inadequate

The provider was rated as Inadequate for safe, effective and well led.

The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk. There was no evidence of joint working with other health and social care services to ensure families, children and young people received multidisciplinary care. Our discussions with three administrative staff we found that staff could not explain the different forms of abuse, such as physical and emotional abuse. They did not know who the lead for child protection or safeguarding at the practice was and were not aware of how to raise concerns.

Immunisation rates were also relatively low for a number of the standard childhood immunisations.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as Inadequate for safe, effective and well led.

Summary of findings

The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice offered online services and health promotion and screening services.

However, there was lack of a clear management structure, and the practice did not have adequate systems in place to monitor and improve quality and identify risk.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as Inadequate for safe, effective and well led.

The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had not worked with multi-disciplinary teams in the case management of vulnerable people. They could demonstrate that only one patient out of around 18 with learning disabilities had received an annual check. Reception staff did not know how to recognise signs of abuse in vulnerable adults and children. They were not aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours or who the safeguarding lead at the practice was.

The practice reported to have around 18 patients with learning disabilities on the register. However they were only able to demonstrate that one patient had a completed check. There were no systems in place to ensure these checks were completed.

Our discussions with three administrative staff we found that staff could not explain the different forms of abuse, such as physical and emotional abuse. They did not know who the lead for child protection or safeguarding at the practice was and were not aware of how to raise concerns.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as Inadequate for safe, effective and well led.

The concerns which led to these ratings apply to everyone using the practice, including this population group.

Some staff had received training on how to care for people with mental health needs and dementia. We found that not all clinical staff were aware of the requirements of the Mental Capacity Act

Summary of findings

2005, and their duties in fulfilling it. None of the GPs had completed recent training on the Mental Capacity Act 2005. There was limited evidence of working with multi-disciplinary teams in the case management of people experiencing poor mental health.

There was lack of a clear management structure, and the practice did not have adequate systems in place to monitor and improve quality and identify risk.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection and received 20 completed comments cards.

Patients reported being happy with the care and treatment they received. All patients we spoke with were complimentary on the attitudes of all staff.

The 2013/14 GP national survey results (latest results published in July 2014) showed that 78% of the respondents had confidence and trust in the last GP they saw or spoke to (Sutton (regional) average: 85%) and 83% said the last GP they saw or spoke to was good at listening to them (Sutton (regional) average: 90%). Other patient experience results showed that 78% of respondents said the last GP they saw or spoke to was good at treating them with care and concern.

Patients reported being happy with the appointments system which they felt suited their needs.

Areas for improvement

Action the service MUST take to improve
Action the provider MUST take to improve

- Ensure significant events are recorded appropriately and discussed regularly.
- Ensure learning from incidents is identified and shared with all practice staff.
- Ensure a regular review of complaints takes place, learning is identified and issues addressed.
- Ensure the practice has the required medical equipment to respond in an emergency.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure formal governance arrangements are in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements
- The practice must ensure that all clinical and administrative staff are properly trained, supervised and appraised. Ensure that reception staff acting as chaperones have Disclosure and Barring Checks (DBS).

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- The practice should also work with other professionals and organisations involved in patients' care to ensure they receive care that is well co-ordinated and effective.
- Actively seek to involve patients in developing and improving the service.
- The practice should ensure they have risk assessments in place and are able to justify the reason for not undertaking location specific Disclosure and Barring Service Checks (DBS) checks such as those for temporary staff.
- Ensure a business continuity plan for the practice is in place.
- Ensure patient feedback is obtained pro-actively.
- Ensure an up to date whistleblowing policy is in place and staff are aware of how to raise concerns.

Dr Hafeez and Partner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist adviser.

Background to Dr Hafeez and Partner

Sutton Medical Practice is a medium sized practice based in Sutton. The practice has a patient list size of 4200. The ethnicity of patients is mainly white British with a small mixed number of Asian and Black Caribbean patients.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostics and screening procedures; family planning; maternity and midwifery services; and treatment of disease, disorder or injury.

The practice is located in a purpose built building. The practice has a full time principal female and male GPs and two locum male GPs .There are also two part time female GPs. The practice has two practice nurses working 30-34 hours per week combined, one full time practice manager and six administrative staff.

The practice holds a Personal Medical Services (PMS) contract for the delivery of general medical services. [Personal Medical Services (PMS) agreements are locally agreed contracts between NHS England and a GP practice. PMS contracts offer local flexibility compared to the nationally negotiated General Medical Services (GMS) contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract)].

The practice had opted out of providing out-of-hours services to their own patients. A local out of hours service, 111, is used to cover emergencies.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

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

• People living in vulnerable circumstances

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and Sutton Healthwatch to share what they knew. The practice is on Band 1 of GP intelligent monitoring. The Bands range from 1-6, with 1 being a high priority for inspection. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey.

We carried out an announced visit on 20 January 2015. During our visit we spoke with a range of staff including GPs, practice manager, practice nurse and administrative staff, and spoke with patients who used the service. We observed staff interactions with patients in the reception area and talked with carers and/or family members. We received 20 completed patient comments cards.

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not have adequate systems to identify risks and improve patient safety. There were no systems to action alerts received from organisations such as the Medicines and Healthcare Regulatory Authority (MHRA). We spoke with the practice nurse who was responsible for vaccinations. They told us they frequently logged onto a specific site to check for any updates and alerts. However this was on an individual basis. Our discussions with the practice manager found that no policy or defined protocols were available for receiving and sharing alerts.

We looked at a few examples of the significant events that had been recorded for 2014. We found that

the details of the incidents were not completed fully and there was lack of a comprehensive discussion around the incidents. We did not find evidence of learning and actions taken to prevent similar incidents happening in the future.

Learning and improvement from safety incidents

The practice had some arrangements in place for reporting, recording and monitoring significant events; however these were not contributing to the practice's learning from safety incidents. Review of the significant event records showed minimal discussion and learning from safety incidents. For example, an incident had occurred where the practice had not informed a patient of their diagnostic results. There was no evidence of how the incident had occurred, no evidence of discussions and learning to prevent such incidents happening in the future and we found that the practice had not implemented a policy or protocol for dealing with diagnostic results.

Reliable safety systems and processes including safeguarding

The practice did not have policies in place relating to the safeguarding of vulnerable adults, child protection and whistleblowing. Training records showed that all staff had received relevant role specific training in safeguarding children and adults. All GPs at the practice had received Level 3 child protection training. The practice nurses had received Level 2 child protection training and reception and administration staff had all received Level 1 training. However from our discussions with three administrative staff we found that staff could not explain the different forms of abuse, such as physical and emotional abuse. They did not know who the lead for child protection or safeguarding at the practice was and were not aware of how to raise concerns.

Clinical staff and the practice manager were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns. However contact details of the local safeguarding teams, in- and out-of-hours safeguarding contacts were not accessible to staff.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments for example children subject to child protection plans or families of concerns had an alert on the individual patient record.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). No chaperone training had been offered at the practice. We spoke to nursing staff and although they had not received training they understood their responsibilities when acting as a chaperone. Reception staff told us that they had been asked to chaperone in the absences of nurses. Though they understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination, no training had been offered and significantly they did not have DBS checks or risk assessments carried out.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. However, there was no clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. For example an incident of power failure had occurred at the practice in August 2014. No system was in place to ensure the incident was recorded and actioned. We observed that on that day the fridge temperatures had been recorded and were within the 2-8 celsius recommendations. However, no learning points had been identified following this incident. We observed two episodes when fridge temperatures had

not been recorded for a period of up to five days in August and September 2014. From our discussions with staff we gathered the nurses were on leave for those days and no arrangements were in place to ensure the fridge temperatures were recorded and monitored.

No formal processes were in place to check and record if medicines were within their expiry date and suitable for use. The nurse told us that they knew how to check the stocks to ensure no medicines were out of stock but there was no system in place for this. However all the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The GP specialist adviser was satisfied with this process. We found some blank prescriptions forms that were in a room that was not locked and could have been easily accessed by patients. We raised this with the practice manager and these prescriptions were immediately removed.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice did not have a lead for infection control. The practice did not have an infection prevention and control (IPC) policy that was in line with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

Staff received induction training about infection control specific to their role and received annual updates. However, there was no evidence of infection control audits being carried out at the practice in the last two years.

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

Sharps were disposed in sharps bins and waste was segregated and stored appropriately. Clinical waste was collected by an external company and consignment notes were available to evidence this.

The practice did not have a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). The practice manager confirmed that no Legionella risk assessment had been completed nor had a check been completed.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. However we observed that equipment used by GPs for home visits such as blood pressure machines had never been checked and calibrated. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We observed that the testing was overdue by two months for most of the equipment. Staff told us that there had been a delay in this being carried out due to an electrical fault.

Staffing and recruitment

The practice did not have an up to date recruitment policy in place. Records we looked at did not contain evidence to show that all appropriate recruitment checks had been undertaken prior to employment. For example, all three locum GPs did not have a Disclosure and Barring Services (DBS) check that had been completed specifically for the practice The practice had used a DBS check completed for the locums by another employer and had no systems in place to assure themselves that this was sufficient.

Monitoring safety and responding to risk

The practice manager explained the systems that were in place to ensure the safety and welfare of staff

and patients. Risk assessments of the premises including fire assessments had been undertaken. The fire alarms were tested monthly. The reception area could only be accessed via lockable doors and glass

screens had been put up in front of the reception desks to minimise potential risks of physical violence towards staff.

Arrangements to deal with emergencies and major incidents

Inadequate

Are services safe?

The practice did not have sufficient arrangements in place to manage emergencies. No emergency equipment was available including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The practice had never had this equipment and there was no risk assessment in place to mitigate the lack of equipment.

Some emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac emergencies, anaphylaxis and hypoglycaemia. The GPs were undertaking flu vaccinations on home visits. However GPs did not carry any emergency medicines for use when on home visits. No risk assessment has been carried out to identify a list of medicines that were required or not suitable for home visits.

The practice did not have a comprehensive business continuity plan. Emergencies were dealt with as they occurred. The practice manager confirmed that this was something they had identified and were in the process of drafting a comprehensive business plan.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The principal GPs attended a local peer group within the CCG. They informed us they discussed difficult cases and sought opinions from other colleagues. However, there were no formal systems in place where alerts and guidance updates were discussed amongst clinical staff to ensure information was cascaded suitably and adapted accordingly. There were also no internal arrangements in place that professionals attending

external courses fed back and shared best practice amongst staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had undertaken data collection required for the CCG. These were linked to medicines management information, as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). However, we did not find evidence to suggest that recommendations of the audit findings had been implemented or there had been widespread learning, and the audit cycle had not been completed to identify changes in patient outcomes. No other audits were shared with us and there was no audit programme with regular planned audits being undertaken to assess and improve various aspects of care delivery.

The performance of the practice as regards to delivery of certain services under Enhanced Service (ES) was currently not being suitably monitored. The new Enhanced Service for 2014-2015 which was aimed at reducing avoidable unplanned emergency admissions to hospitals requires patient care plans to be in place for all patients initially added to the unplanned admissions register by the end of September 2014.The practice manager told us that they had not fully implemented the care plans as required.

Similarly, the learning disabilities health check scheme ES is designed to encourage practices to identify patients aged 18 or over with the most complex needs and offer them an annual health check. The practice reported to have around 18 patients with learning disabilities on the register.However they were only able to demonstrate that one patient had a completed check. There were no systems in place to ensure these checks were completed.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The electronic recording system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The practice had an overall QOF score of 761 points out of 900 for the previous year.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, infection control, confidentiality awareness, child protection and safeguarding. However the practice did not have sufficient systems in place to ensure that staff had sufficient knowledge they could apply after attending the training. For example all the administrative staff had recently completed child protection level 1 training. From our discussions with them they could not tell us who the lead for child protection at the practice was nor could they described the different types of abuse.

All GPs were up to date with their yearly continuing professional development requirements. However they were unaware of their re-validation dates. The practice had records supplied by the practices nurse that showed their registration with the Nursing and Midwifery Council (NMC) was current.

Inadequate

Are services effective?

(for example, treatment is effective)

Not all staff had received an appraisal within the last 12 months. The practice manager and the practice nurses had not had their appraisals since May 2013. The practice nurses received appropriate training updates that enabled them to carry out specific roles such as vaccinations and other specialist role and this training was offered regularly within the local Clinical Commissioning Group.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, they had completed training on administration of vaccines, cervical cytology and the yearly Yellow fever refresher course.

Working with colleagues and other services

Blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service were received both electronically and by post. The practice did not have a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers.

The practice manager and both GPs were not clear about the policy for dealing with blood test results and other diagnostic tests. Our discussions with all staff identified that there was no ownership or responsibility in dealing with these. The practice manager explained that the doctor on duty would deal with results as they came in. One GP told us that they acted on these results as they came in and the other GP reported that they would follow through results of patients they had referred.

We found that a blood test result received on 30 December 2014 that required being actioned was left in the inbox of received results without being filed or matched to the patient's records. We also found that another result received on 9 January 2015 had not been acted on. We viewed patient records and found that two patients had attended GP appointments after their diagnostic test results had been received and no discussion of these results had taken place. In another case a patient had been sent back for testing even after the original results had been received and not acted on.

Multidisciplinary team meetings were not held at the practice. The practice manager liaised with the health visitor to identify children and families of concerns However no system was in place to ensure this information was effectively shared within the practice. No other agencies were involved such as palliative care nurses, district nurses for end of life care or community mental health teams for patients with mental health or learning disabilities.

Information sharing

We had met the Sutton CCG prior to our inspection visit to share information. The CCG told us that the practice regularly attended the network meetings.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 58% of referrals last year through the Choose and Book system. (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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the accident and emergency unit. The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used electronic patient records to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that not all clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. None of the GPs had completed recent training on the Mental Capacity Act. One of the GPs did not understand the key parts of the legislation though

Inadequate

Are services effective?

(for example, treatment is effective)

was able to describe how they implemented it in their practice. Examples provided were around working and supporting patients with dementia or learning disabilities to be supported to make decisions.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

There was a range of information available to patients in the waiting areas which included leaflets and posters providing information on the various services, flu vaccinations and smoking cessation. New patient checks were undertaken by the practice nurses.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 55% of patients in this age group took up the offer of the health check.

The practice's performance for cervical smear uptake was 76%, the average within the CCG area was 81%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data shared with us by the practice showed that they were achieving

about 87% coverage for the course of the DTaP / Polio / Hib Immunisation (Diphtheria, Tetanus, acellular pertussis (whooping cough), poliomyelitis and Hemophilus influenzae type b). The practice was also achieving over 92% for meningitis C immunization and 78% for Rotavirus. The practice had delivered 56% of seasonal flu vaccinations to patients aged 65 and older. This was very low compared to the average of the CCG which was 73%.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and completed CQC comment cards to provide us with feedback on the practice. The national patient survey results showed that 78% of the respondents had confidence and trust in the last GP they saw or spoke to (Sutton (regional)

average: 85%) and 83% said the last GP they saw or spoke to was good at listening to them (Sutton (regional) average: 90%). Other patient experience results showed that 78% of respondents said the last GP they saw or spoke to was good at treating them with care and concern.

We received 20 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that all consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

The practice had a chaperone policy and details of how to request a chaperone were displayed in areas easily accessible to patients. Records confirmed that staff had not completed the chaperone training at the practice. However staff we spoke with were able to fully explain what the role involved.

Care planning and involvement in decisions about care and treatment

We reviewed ten patient records. We noted that all patients had been involved in the care planning of their care. Decisions on the care options available had been discussed fully.

We noted that where appropriate patients had been involved in making decisions about the hospitals they wished to receive their care from. Patients we spoke with told us that the GPs respected their decisions of requesting care at hospitals that were not within the area. Data from the national patient survey showed that, 72% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care compared to 81% from the local CCG average.

Suitable information and support regarding their care and treatment was provided. Healthcare leaflets were available for patients, and posters with healthcare information were displayed in the waiting area and consultation rooms. The practice's website was up-to-date and provided a wealth of information ranging from the various services, clinic times and the various activities being undertaken by the practice. Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The practice provided support to patients during periods of bereavement. Information leaflets were available at the practice containing the list of support organisations available. Information on how to register a death and local funeral directors was included in the practice leaflet. The GPs referred patients for counselling when needed.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Patients had a choice of seeing a female or male GP at the surgery. Both GPs had been working at the surgery for a number of years and had developed relations with patients which allowed continuity of care. The practice used the same locum staff if needed and so patients were also familiar with them.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services and one of the GPs spoke multiple languages including Urdu and Punjabi that were commonly used languages by the local ethnic minority population.

Online facilities were available for repeat prescription requests and nurse appointments. Staff told us that they had also recently introduced GP appointments online and were making patients aware of this. We asked staff to explain the process of requesting emergency appointments .They were clear in explaining the procedure and how they would transfer all urgent calls to the on- call GP for triage. We were shown emergency appointments that were available on the day of our inspection. These appointments included slots for children and the elderly.

The practice was accessible to patients from disadvantaged groups such as asylum seekers, those from travelling communities or those with learning disabilities. They ensured health promotion interventions such as smoking cessation, smear checks and family planning were available for these patient. Staff had completed diversity training to help them understand the different needs of patients.

Patients who were too ill to attend the surgery were visited at home by the GPs. This also included home visits for flu vaccines for patients who were housebound.

Access to the service

Appointments were available from 08:00 am to 08:00 pm on Monday, Tuesday, Wednesday and Fridays. Wednesday appointments were from 08:00-6:30pm. The practice offered 20% book on the day appointments and advance appointments could be booked three weeks in advance.

Appointments could be booked by phone, online and in person. There was a daily 'on-call' doctor system for patients with urgent needs. The practice also offered the facility of telephone consultations where the receptionist would ask for a brief description of the reason for the call and the GP would phone the patient back the same day.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits, request prescriptions, registrations for new patient's both long term and temporary, and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information was available via the answer phone and the practice's website, providing the telephone number patients should ring if they required medical assistance outside of the practice's opening hours.

Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients we spoke with and the comments cards received showed patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day they contacted the practice.

The practice's extended opening hours four times a week was particularly useful to patients with work commitments. This was confirmed by the comments cards we received.

The practice was situated on the ground floor. We saw that the waiting area was able to accommodate patients with wheelchairs and prams .The waiting room was small but allowed access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Listening and learning from concerns and complaints

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

The practice had some arrangements in place for handling complaints and concerns. The practice had a complaints handling procedure and the practice manager was the designated staff member who managed complaints. We saw that information was available to help patients understand the complaints system .This was included in the practice information leaflet and displayed in the reception area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We noted that the practice had received eight complaints since August 2014. No processes were however in place to demonstrate how the complaints had been dealt with. We could not ascertain whether patients had been responded to in an appropriate way.

The practice did not appear to have a system in place for analysing and learning from complaints received in the practice. Not all complaints had learning points. There were no formal meetings attended by clinical and non-clinical staff to discuss the complaints, to ensure they were handled appropriately, analysed and lessons learned. As a result the practice had not implemented measures to reduce future occurrence and we identified the same trends in complaints being received.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

Although the practice had a vision staff was unable to explain their understanding of the values and how they would promote them to provide good care to patients. There were no records to indicate where these values were discussed or shared with staff and goals set to ensure they were being met. The practice had a vision to deliver high quality care and promote good outcomes for patients. We saw the practice's vision and strategy displayed on the practice website and on leaflets in the surgery. This stated that Dr Hafeez Practice philosophy was, "to be accessible to our patients and provide high quality primary care.

Governance arrangements

The practice did not have clear governance arrangements in place. The practice held no governance meetings, it was not clear who the governance lead was or the processes that were in place to identify poor quality services and performance and explore all the contributory causes and interventions to correct them. For example, the practice did not have a policy on how blood tests and other diagnostic tests were followed up. Our discussions with both clinical and administrative staff found that they all followed different procedures in dealing with these. As such no one took responsibility and accountability.

Leadership, openness and transparency

The practice was led by two partners and the practice manager. Discussions with all staff demonstrated lack of clarity amongst staff on how decisions were made and who had overall responsibility.

Although all staff were clear that the principal GPs were the leads they were unsure of their responsibilities. For example, it was not clear at the practice who the lead for safeguarding was. The practice manager took the lead in the administration and liaison with professionals such as the health visitor and would report back to the GPs. Our discussions with the GPs found that they were unsure of this process.

The practice did not hold regular staff meetings. The practice had minutes available of two meeting for the year 2014. However staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues informally on a day to day basis with the practice manager.

Seeking and acting on feedback from patients, public and staff

The practice had a Patient Participation Group (PPG).The group had recently started and meetings had taken place. The practice manager was aware of the need to facilitate the development of the group to ensure patient were views obtained. A plan was in place to establish meetings and the practice was encouraging patients from different backgrounds and ages to be part of the group.

The practice had not completed any other patient surveys.

No whistleblowing policy or procedure documents were in place and staff were not aware of how they would report a concern.

Management lead through learning and improvement

There were a lack of systems in place that enabled learning and improvement of performance.

We found limited evidence of learning and sharing of information to help improve care delivery. We found there was a lack of effective discussions around incidents and significant events with no learning and actions being taken to prevent similar incidents happening in the future. Non-clinical staff were not able to talk us through an incident they had learnt of through discussions in team meetings. The GPs and practice manager gave us examples of incidents that had occurred or near misses but could not easily explain the measures that were in place to avoid future occurrence.

Similarly, the practice did not appear to have a system in place for analysing and learning from complaints received in the practice. There were no formal meetings attended by clinical and non-clinical staff to discuss the complaints, ensure they were handled appropriately, analysed and lessons learned.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.** **The provider had not made suitable arrangements for dealing with medical emergencies because no emergency equipment was available. Regulation 9 (2).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 HSCA (Regulated Activities) Regulations 2010 Cleanliness and infection control.** **The provider did not have an Infection control policy and no infection control audits were taking place.** **Regulation 12 (a)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision How the regulation was not being met: The registered person did not have systems in place to ensure that adequate governance and monitoring systems were in place. No processes were in place to check medicines were within their expiry date and suitable for use No systems were in place to ensure staff were supported through appropriate training, supervision, and appraisal. There were no systems to ensure consistent learning through significant event analysis was taking place and shared with staff No systems were in place to ensure administrative staff had adequate safeguarding knowledge to enable them to identify abuse to protect people using the service.