Dr Surendra Kumar Dhariwal

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This inspection was a follow up to earlier inspections carried out on 29 June 2016 and 22 March 2017.

Following the inspection on 29 June 2016 the practice was rated inadequate in the provision of safe, effective and well-led and requires improvement in caring and responsive services. It was rated inadequate overall and placed in special measures. There were breaches in relation to the following regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Regulation 11 the Need for consent, Regulation 12 Safe care and treatment, Regulation 15 Premises and equipment, Regulation 17 Good governance, Regulation 18 Staffing, and Regulation 19 Fit and proper persons employed. After the inspection the provider submitted an action plan detailing how it would make improvements and when the practice would be meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Following the inspection on 22 March 2017, which we carried out to consider whether sufficient improvements had been made and to identify if the provider was meeting legal requirements and associated regulations, the practice was rated inadequate in the provision of safe, effective and well-led, requires improvement in caring, good in responsive and inadequate overall and remained in special measures. The provider had made improvements; however there continued to be breaches of Regulation 12 Safe care and treatment, Regulation 17 Good governance, Regulation 18 Staffing, and Regulation 19 Fit and proper persons employed. After the inspection the provider submitted an action plan detailing how it would make further improvements and when the practice would be meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection was undertaken following the period of special measures and was an unannounced comprehensive inspection on 3 July 2017. Overall the practice remains rated as inadequate.

At our inspection on 3 July 2017 we found:

Summary of findings

- Staffing arrangements were unclear and there were gaps in maintaining relevant staff checks or information such as Disclosure and Barring Service (DBS) and clinician's medical indemnity insurance and immunity.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance but there were weaknesses in staff appraisal procedures and training.
- There were gaps in safety arrangements such as safety alerts follow up and managing unforeseen staff absence.
- Areas of the premises were dusty and some items were visibly dirty or out of date.
- A significant amount of medicines and equipment were not fit for use and there were no effective systems in place to address this.
- There was no evidence of clinical or other quality improvement activity.
- There was a system in place for reporting and recording significant events but it was ineffective. Significant events had not been captured to make improvements or monitor trends to take action to prevent future recurrence.
- The mission statement, vision and strategy were unclear and there were no business plans and operational structures had weaknesses.
- Staff were aware of current evidence based guidance and worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Patients said they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Patients 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.
- There was no evidence of the duty of candour or that lessons were learned from individual concerns and complaints or analysis of trends and action taken as a result to improve the quality of care.

Importantly, the provider must:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure all premises and equipment used by the service provider is fit for use.
- 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.
- Maintain all necessary employment checks for all staff.

In addition the provider should:

- Review arrangements for patient's access to information and services online.
- Review systems for signposting carers and embed polices and guidance.
- Ensure the most recent CQC rating is clearly displayed and provide accurate information to the CQC as required.
- Review reception staffing and chaperoning cover arrangements.
- Review and improve arrangements for relevant staff safeguarding and administering vaccinations updates or training.

This service was placed in special measures on 3 November 2016. Insufficient improvements have been made such that there are ratings of inadequate for safe, effective, caring, responsive, well-led and overall. We took enforcement action and decided to cancel the providers' registration and the provider appealed this decision. The case was heard in court at a First Tier Tribunal that decided it was not disproportionate for CQC to cancel the providers' registration.

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.

- There were dangers and hazards including expired injectable medicines, electrical equipment that had failed safety testing, and arrangements for Control of Substances Hazardous to Health (COSHH) were ineffective.
- There were gaps in systems, processes and practices in place to keep patients safe such as following up managing unforeseen staff absence, safety alerts, staff checks including immunity status, medical indemnity and Disclosure and Barring Service (DBS) checks, and identification and management of significant events.
- When things went wrong reviews and investigations did not take place and lessons were not learned to improve safety in the practice.
- Some risks such as legionella had been managed effectively but others had not, such as infection prevention and control and fire safety.
- Refrigerated and emergency medicines and equipment were mostly fit for use but there were no systems in place to ensure this was sustained.
- Areas of the premises were dusty and some items were visibly dirty or out of date.
- A significant amount of medicines and equipment were not fit for use and there were no effective systems in place to address this.
- The business continuity plan was not tailored to maintain operational effectiveness in the event of unplanned staff absence.

Are services effective?

Inadequate

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

- There was no evidence that audit was driving improvement in patient outcomes.
- Arrangements for some staff roles for female patient care were insufficient or unclear such as female clinicians to undertake cervical screening.

Summary of findings

- Staff assessed patients' needs and delivered care in line with current evidence based guidance but there were weaknesses in staff appraisal procedures and training.
- There were gaps in evidence of clinicians' medical indemnity insurance and immunity status checks.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to or above local and national averages, with the exception of breast cancer screening which was below average and exception reporting for cervical screening was above average.
- Staff were aware of current evidence based guidance and worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- There was evidence end of life care was coordinated with other services involved. However, a local care home the practice provided GP services to told us the practice offered little or no GP participation in end of life and advance care planning.

Are services caring?

Inadequate

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

- July 2017 data from the national GP patient survey showed patients rated the practice as comparable to CCG averages and slightly below national averages for aspects of care and the practice had not taken action to understand or improve its lower July 2016 GP patient survey results.
- The main multi lingual appointment check in screen in the reception area had been repaired, the second screen did not connect to the appointment system but staff had access to translation services and spoke several languages between them.
- The practice did not have a website but leaflets in the reception area were available to direct carers to relevant support services.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treated patients with kindness and respect but there were gaps in arrangements for patient and information confidentiality.
- There was no system for signposting carers to the various avenues of support available to them except products sales leaflets in the reception area.

Summary of findings

Are services responsive to people's needs?

Inadequate

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

- There was no evidence lessons were learned from individual concerns and complaints or analysis of trends and action was taken to as a result to improve the quality of care.
- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, the practice provided a weekly visit to a 60 bedded home for older people living in a local residential home; however, feedback from the care home indicated some concerns.
- Data from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to or above local and national averages.
- The practice took account of the needs and preferences of patients with life-limiting conditions.
- 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 facilities to treat patients and meet their needs.
- The provider did not have a website or specific plans to create one but offered online appointment booking and prescription requests through the online national patient access system.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made.

- The practice did not have a clear vision and strategy and there were no business plans.
- The practice had a mission statement; staff were not aware of it but knew the values of the practice were to be caring.
- There was no clear leadership structure but staff felt supported by management.
- The practice had a number of policies and procedures to govern activity, but staff recorded as responsible for them were not aware of this and many were either not implemented or were out of date such the cold chain policy for refrigerated medicines and the needle stick and splashing injuries had not been reviewed since October 2003.

Summary of findings

- The lead GP was the decision maker and lead for all aspects of strategic and managerial work, and operational and clinical services delivery. Some staff expressed concerns regarding these arrangements.
- Staffing levels could not be determined across several roles and there was no clear list of staff delegated responsibilities. However, staff felt supported by the lead GP.
- Arrangements for safety had weaknesses including in fundamental areas such as following up safety alerts, staff employment checks and infection prevention and control.
- Evidence of a process for quality improvement was limited to discussions with patients through the patient participation group (PPG).
- There were gaps in arrangements for patient's confidentiality.
- Arrangements for meetings were ad hoc and informal; there were no meeting or structure for actions agreed or for follow up.
- The practice had systems in place for notifiable safety incidents and to support compliance with the duty of candour but they had not been used, staff told us information was shared. There was no evidence action was taken to improve individual patient's care or systems in place.

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 is rated as inadequate for safe, effective, caring, responsive and for well-led. The issues identified as inadequate overall affected all patients including this population group.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- GPs provided a visiting doctors round to residents at a 60 bedded local care home. Feedback from the care home was not positive and indicated concerns including insufficient and delayed repeat prescribing for dressings and food supplements, and a lack of end of life and advance care planning, communication including with residents families in relation to medicines and practice manager cover.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services such as adult social care teams.
- The practice participated in an initiative to improve preventative medical care for frail older patients and avoid unnecessary admissions into hospital.

People with long term conditions

Inadequate

The provider is rated as inadequate for safe, effective, caring, responsive and for well-led. The issues identified as inadequate overall affected all patients including this population group.

- Performance for diabetes related indicators was similar to national averages. For example, the percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c (blood sugar level) was 64 mmol/mol or less in the preceding 12 months was 84%, compared with the CCG average of 72% and national average of 78%.
- The percentage of patients with hypertension having regular blood pressure tests was 87%, which is similar to the CCG 82% average of and national average of 83%.

Summary of findings

- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale was 100% compared to 87% within the CCG and 90% nationally.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The provider is rated as inadequate for safe, effective, caring, responsive and for well-led. The issues identified as inadequate overall affected all patients including this population group.

- 87% of patients diagnosed with asthma, on the register had an asthma review in the last 12 months compared to 76% nationally.
- Childhood immunisation rates for under two year olds were 94%, (the national expected coverage of vaccinations is 90%); and the Measles, Mumps and Rubella (MMR) vaccine for five year olds was 100% for Dose 1 compared to 94% nationally; and 100% for Dose 2 compared to 88% nationally.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Data for female clinical care was below average and no effective action had been taken to understand or address this. The practice's uptake for the cervical screening programme was 87%, which was comparable to the national average of 81%. However, exception reporting was relatively high at 26% compared to 11% within the CCG and 7% nationally.
- Females aged 50-70, screened for breast cancer in last 36 months was 51% compared to 59% within the CCG and 73% nationally. Females aged 50-70, screened for breast cancer within 6 months of invitation was 0% compared to 63% within the CCG and 74% nationally.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The provider is rated as inadequate for safe, effective, caring, responsive and for well-led. The issues identified as inadequate overall affected all patients including this population group.

- The practice did not have a website or specific plans to create one but offered online appointment booking and prescription requests through the online national patient access system.
- The practice offered a range of health promotion and screening that reflects the needs for this age group.
- The practice offered extended hours from 6.30pm until 7.00pm on Tuesdays and Fridays for working patients who could not attend during normal opening hours.
- Telephone consultations with clinicians were available to meet the needs of this population group.

People whose circumstances may make them vulnerable

Inadequate

The provider is rated as inadequate for safe, effective, caring, responsive and for well-led. The issues identified as inadequate overall affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice had five patients on the register with a learning disability, three (60%) of these patients had received an annual health check in the last 12 months.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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)

Inadequate

The provider is rated as inadequate for safe, effective, caring, responsive and for well-led. The issues identified as inadequate overall affected all patients including this population group.

Summary of findings

- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to national average of 84%.
- 94% of patients diagnosed with a mental health had a comprehensive documented agreed care plan which was comparable to national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia and carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with or above local and national averages. Three hundred and fifty four forms were distributed and eighty six were returned. This represented 7% of the practice's patient list.

- 90% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 73% and the national average of 84%.
- 77% described the overall experience of their GP surgery as fairly good or very good compared to the CCG average of 73% and the national average of 85%.
- 58% said they would recommend their GP surgery to someone who has just moved to the local area compared to the CCG average of 65% national average of 77%.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The practice friends and family test patient's satisfaction scores during April and May 2017 showed 100% said they would recommend the surgery.

Areas for improvement

Action the service MUST take to improve

Importantly, the provider must:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure all premises and equipment used by the service provider is fit for use.
- 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.
- Maintain all necessary employment checks for all staff.

Action the service SHOULD take to improve

In addition the provider should:

- Review arrangements for patient's access to information and services online.
- Review systems for signposting carers and embed polices and guidance.
- Ensure the most recent CQC rating is clearly displayed and provide accurate information to the CQC as required.
- Review reception staffing and chaperoning cover arrangements.
- Review and improve arrangements for relevant staff safeguarding and administering vaccinations updates or training.

Dr Surendra Kumar Dhariwal

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 Surendra Kumar Dhariwal

Dr Surendra Kumar Dhariwal (also known as Manor Park Medical Centre) is situated within NHS Newham Clinical Commissioning Group (CCG). The practice provides services to approximately 1,350 patients under a Personal Medical Services (PMS) contract.

The practice was registered with the Care Quality Commission (CQC) to carry on the regulated activities of maternity and midwifery services, family planning services, treatment of disease, disorder or injury, surgical procedures, and diagnostic and screening procedures. In June 2016 the Lead GP told us minor surgery and family planning had not been undertaken for a long time and we asked the provider to update their registration. However, the practice had not applied to CQC to remove minor surgery or family planning as a regulated activity.

Staff include: the lead male GP working seven sessions per week, and two long term male locum GPs (one working two sessions per week and the other as and when in the event the Lead GP goes on holiday); one or two female practice nurses working seldom and ad hoc, a practice secretary working 25 hours per week (five hours every weekday), a receptionist working 20 hours per week, and a records summariser working ad hoc.

The practice premises are on the ground floor of a converted semi-detached house. Its core opening hours are between 8:00am to 6.30pm every weekday. GP appointments are from 9.00am to 11.00am and 4.00pm to 6.00pm, except on Thursday when there is no afternoon session but the doors of the practice remain open. The practice offers on-site extended hours GP appointments from 6.30pm until 7.00pm on Tuesdays and Fridays. Patients telephoning when the practice is closed are directed to the local Newham GP Co-op out-of-hours service provider. Appointments include pre-bookable appointments, home visits, telephone consultations and urgent appointments for patients who need them. GPs provide a visiting doctors round to residents at a 60 bedded local care home and related information is included in this report.

The Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten - level one representing the highest levels of deprivation. The practice has a relatively high population of older patients compared to the local CCG. Data showed 19% of its patients were over 65 years of age compared to 7% within the CCG and 17% nationally.

The practice was previously inspected on 29 June 2016 when it was rated inadequate overall and placed in special measures. There was a follow up inspection on 22 March 2017 when the practice was rated inadequate overall, and accordingly remained in special measures for a further six month period.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service on 3 July 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We had previously carried out an announced comprehensive inspection at Dr Surendra Kumar Dhariwal on 29 June 2016 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 Care Act 2014. The provider was rated inadequate for the provision of safe, effective and well-led services and requires improvement for provision of caring and responsive services. Specifically, it was found to be in breach of Regulations 11 (Need for consent), 12 (Safe care and treatment), 15 (Premises and equipment, 17 (Good governance), 18 (Staffing) and 19 (Fit and proper persons employed) of the Health and Social Care Act (Regulated Activities) Regulations 2014 and placed in special measures.

A follow up inspection was carried out on 22 March 2017. Limited improvements had been made since the inspection in June 2016 and the practice was rated inadequate overall and remained in special measures for a further six month period. This inspection on 3 July 2017 was planned to consider whether sufficient improvements had been made and to identify if the provider was now meeting legal requirements and associated regulations.

All reports can be found at the following link – http://www.cqc.org.uk/location/1-494244240/reports

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and Newham Clinical Commissioning Group (CCG) to share what they knew. We carried out an unannounced visit on 3 July 2017.

During our visit we:

- Spoke with a range of staff (Lead GP, a practice secretary, and a member of reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.

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

We also looked at how well services were provided for specific groups of people and what good care looked 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 whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia)

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.

Inadequate

Are services safe?

Our findings

We first inspected the practice under the current Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on 29 June 2016. At that inspection we rated the practice as inadequate for providing safe services as the arrangements in respect of responding to a medical emergency and first aid, significant events, safety alerts, chaperoning, recruitment checks, medicines and prescriptions management, legionella, staff rotas and planning, fitness of premises and equipment including safe operation and cleanliness, infection control, business continuity planning, and various staff safety training including safeguarding were not adequate.

At our follow up inspection on 22 March 2017, we rated the practice as inadequate for providing safe services. The arrangements in respect of significant events, safety alerts, chaperoning, cleanliness and infection control, safe management of emergency medicines and equipment and refrigerated medicines, staff rotas and planning, systems to ensure premises and equipment safety checks, safe storage of cleaning equipment, business continuity planning and staff rota planning were not adequate. We also found expired clinical items, and insufficient staff basic life support training, a lack of job descriptions, recruitment checks, clinician's medical indemnity insurance and staff immunity status checks.

At this inspection, chaperoning arrangements had improved and staff had received basic life support training, but safety systems or processes continued to have significant weaknesses. The practice remains rated as inadequate for providing safe services.

Safe track record and learning

There was a system in place for reporting and recording significant events but significant events were not identified or managed to prevent future recurrence.

- Staff told us they would inform the lead GP of any incidents and there was a significant events recording form that 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). There was also a diary for recording incidents in the reception area.
- There had been no significant events since our previous inspection 22 March 2017 and opportunities to capture and learn from significant events were missed such as issues identified at our previous inspection including a patients cervical screening test result that had not been received or followed up, safety alerts not being dealt with, and out of date items found in the practice were not treated as significant events. All these issues posed a risk to patients but there was no evidence the practice carried out a thorough analysis of significant events or that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology or were told about any actions to improve processes to prevent the same thing happening again.
- We asked to see safety records, incident reports and minutes of staff meetings held where general safety issues were discussed but there had been no staff meetings since our previous inspection and there was no method to ensure agreed actions or completion of actions required. Staff told us ad hoc meetings had been held but these were not minuted. The lead GP was aware of safety alerts but there was no effective system to ensure effective follow up. We checked safety alerts against records for patients taking specific medicines that may have been at risk and found one patients' blood tests were overdue by more than a year which was brought to the attention of the lead GP; however, we subsequently received no assurance the matter had been dealt with. After inspection we followed up with the provider again and alerted NHS England and the local CCG to ensure appropriate action was taken to ensure patients safety.

Overview of safety systems and processes

Not all systems, processes and practices in place kept patients safe:

- 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. The lead GP was the lead member of staff for safeguarding. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had

received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3 and non-clinical staff were trained to level 1. One of the two practice nurses was safeguarding trained to level 3 but there was no evidence of safeguarding training for the other practice nurse and we were unable to verify whether they were appropriately trained.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role but not all had received a Disclosure and Barring Service (DBS) check and no suitable risk assessment was in place. (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 made a search of records relating to chaperoning arrangements especially as all three GPs at the practice were male and practice nurse cover was limited and found chaperones had been routinely offered and had attended appointments as needed. Non-clinical staff told us when they were called to undertake chaperoning duty they would leave the reception area unattended but lock it to ensure security. We noted clinical staff had made an entry into patients notes that a chaperone was present, but the chaperone was not named and the member of staff who carried out the chaperone duty did not make any entry onto the record.
- The practice did not always maintain appropriate standards of tidiness or hygiene but premises and equipment cleaning had mostly been undertaken. Cleaning schedules were in place and had been signed but some items were visibly dirty or dusty such as placebo inhalers and antibacterial hand gel. The practice was cluttered such as a box of various patients documents in a cardboard box on top of a printer that was switched on and a potential fire safety risk, and chargers switched on in drawers of clinical trolleys, some that were over filled to the extent they could not be opened or closed without obstruction. There were leaflets and other papers on surfaces gathering dust and areas of the practice needed redecoration or refurbishment such as tiles at the rear of the interior of the practice either fallen or falling off and carpets that were visibly stained. There was only one mop to clean both clinical and patients toilet areas.
- The most recent external Infection Prevention and Control (IPC) audit arranged by the NHS North East London Commissioning Support Unit had been carried out 20 July 2016 and identified multiple concerns. We saw the audit noted that infection compliance had fallen from 78% on 13 June 2016 to 69% on 20 July 2016 and that urgent action continued to be required. We saw the provider had agreed plans of actions to be carried out including immediate or within two to four weeks. Some of these actions had been completed such as updating the IPC Policy, ensuring infection control training for staff (however the cleaner that dealt with sharps and clinical waste had not been trained as required), carpets had been replaced with sealed impervious flooring in clinical rooms and in date spillage kits (used for cleaning up spillages of bodily fluids such as vomit) were provided. However, other actions had not been completed such as risk assessment for sharps management practices, ensuring clinical trolleys are kept free from clutter to minimise risks of dirt and dust accumulation and allow easy cleaning, ensuring up to date Health Protection Unit contact details availability and display for staff, immunity status for relevant staff, and disposal of out of date items. We also noted the needle stick and splashing injuries protocol remained not been reviewed since October 2003. There was no system to ensure six monthly cleaning of patient's privacy curtains, but they were visibly clean and were marked as last cleaned 13 December 2016.
- Not all arrangements for managing medicines, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were mostly in place for handling repeat prescriptions which included the review of high risk medicines but we found relevant clinical monitoring of blood test results had not been carried out for a patient on a high risk medicine. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions (PGDs) had been adopted by the practice to allow one of the nurses to administer medicines in line with legislation but were not applicable as we were told that nurses did not

administer medicines. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

- The medicines refrigerator contained a bottle of cola and three medicines refrigerator thermometers, each with a different temperature reading and a vial of what appeared to be an injectable medicine expired in 2008. The lead GP told us this was an old testing kit that was not in use or intended for a patient's injection. The lead GP also told us multiple thermometers were needed at different height levels of the refrigerator because the inner temperature varies; however, this is not the case. Medicines refrigerator temperature monitoring records showed temperatures required to assure medicines safety had gone out of range to nine degrees Celsius during two days in 20 June 2017 (the recommended safe range is between two and eight degrees Celsius). No action had been taken to check medicines' safety and the person delegated to read the temperatures thought the safe range was between three and ten degrees Celsius. We bought this to the attention of staff including the lead GP on the day of inspection but received no assurance the matter had been dealt with after inspection. We followed up with the provider again and also alerted NHS England and the local CCG to ensure patients safety. The provider later responded but the information provided continued to not demonstrate an appropriate level of action to ensure safe refrigerated medicines management.
- At the beginning of the inspection we noted a room directly off the waiting room was open that contained safety hazards such as the clinical waste bin that was also open, methylated spirits and other hazardous substances as well as a further cupboard that was open and housed what appeared to be the IT servers with wires protruding out of the cupboard. Staff told us the room was usually locked and was being used; however, there was no evidence of it being used and no staff member returned to lock the area although we ensured was locked shortly after inspecting it. The whole of the rear of the practice premises was also open and accessible to patients and the key to secure it could not be found. There were numerous safety concerns including significant fire and other safety risks. For example, the area carpets were thick pile and presented a trip hazard, the rooms were packed or piled high with various clutter including methylated spirits, stacks of papers, an expired oxygen gas bottle, printers, keyboards, lamps and items that had failed electrical safety testing, battery chargers in drawers plugged in and charging, and heaters and other items that had failed electrical safety testing. There was a trolley full of out of date items including injectable medicines such as vials containing adrenaline that expired 2002, ventolin expired 2001, furosemide expired 2006 and 1994, hydrocortisone expired 2001, largactyl expired 2001, atropine expired 1992 and diazepam expired 1984, and syringes expired 2005. We also found expired items in clinical rooms in use such as sharps expired May 2017, paediatric nebuliser masks expired 2016, and medical wipes expired 2005. One member of staff told us the key to secure the back of the practice had been missing for a couple of weeks and another told us it was a few days. The day after inspection the lead GP told us the key was found.
- We reviewed six personnel files and found gaps in Disclosure and Barring Service (DBS) and other staff checks. For example, most clinician's files showed no evidence of medical indemnity insurance and immunity status checks. This entailed a risk to patients because if for any reason a patient has suffered harm as a result of a clinicians care, it is a legal requirement that clinicians have adequate and appropriate insurance or indemnity to potentially compensate the patient depending on the individual circumstances. Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK. There were no arrangements for regularly reviewing the immunisation status of relevant staff as necessary in line with Immunisation against infectious diseases schedules, including for staff providing vaccinations to prevent or reduce the risk of cross infection under The Health and Safety at Work Act 1974.
- The DBS check for one of the two locum GPs dated back to 2010 and the remaining locum GP had no DBS check on file. Both locum GPs were described as working at the practice for a long time. At our inspection on 29 June 2016 the practice showed us NHS England national performer list information for the two locum GPs, one was dated 20 October 2010 and the other 14 June 2016. (The NHS England performers lists provide an extra layer of reassurance for the public that GPs practising in the

NHS are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks such as with the Disclosure and Barring Service and the NHS Litigation Authority). There were no references checks on either of the locum GP files or for a practice nurse. Identification checks with the exception of for one practice nurse were in place but most staff roles had no job description, including all clinical staff and the practice secretary. The lead GP told us the provider was in the process of applying for staff DBS checks but had not yet completed the process with a DBS checking agency. After our inspection at the end of August 2017, the provider submitted evidence of recent DBS checks for all non-clinical staff that were chaperones, the Lead GP, and a prospective member of clinical staff but this did not address all the gaps we identified at our inspection.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety but risks to patients were not always managed.

- There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. It appeared most electrical equipment was checked to ensure the equipment was safe to use but there was no inventory of electrical equipment and there were at least seven electrical appliances that had failed safety testing and were in use or had not been repaired or disposed of. For example, a lamp in a clinical room, a fan with bare wires that was plugged in in the waiting room and heaters including a floor heater that was visibly melted. There was no inventory of clinical equipment, most was checked to ensure it was working properly but there was no evidence other items had been checked since 2014 or at all including a blood pressure monitoring machine, weighing scales and height meters. The practice had a variety of other risk assessments in place 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). However, substances hazardous to health such as cleaning chemicals, methylated spirits in two areas of the practice and DIY materials had not been securely stored. We noted the boiler cupboard door was separated in two halves, the bottom half was locked and the top half was open and accessible including boiler controls and pipes with items stored between and around the pipes.
- The examination couch in one of the two clinical rooms was not height adjustable and would not be accessible for some people to climb onto and increased the risk of losing balance; this issue had been noted at our inspection 29 June 2016. There was an adjustable examination couch kept in the other clinical room. Several of the peak flow meters were obsolete.
- The practice had up to date fire risk assessments and staff told us fire drills were carried out but had not been recorded, after the inspection the provider sent us a hand written record of a fire drill dated 21 March 2017. Fire extinguishers were slightly overdue a check since 8 June 2016 and there was no system to ensure future checks. Staff were trained in basic fire safety but there was no trained fire marshal to take the lead effectively in the event of a fire as was identified in the fire risk assessment dated 19 August 2016, also seen at our 22 March 2017 inspection. Some of the fire action signs had fallen off the wall and there were none at the rear of the practice where the fire exit was locked shut with a mortice lock and had no key.
- There was no rota system in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs such as female clinical staff cover. Arrangements were informal and there was evidence they were not workable or satisfactory. Staff knew their usual rota and covered each other ad hoc if necessary but staff that were expected on duty at 4pm did not turn up and other staff were unsure why and stayed on to cover.

Arrangements to deal with emergencies and major incidents

Not all arrangements were in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency and all staff excepting one had received basic life support training, there was no indication this training was planned or overarching system to show a plan for staff training.

Inadequate

Are services safe?

- 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. There was no emergency use aspirin for example for use in the event of a suspected myocardial infarction (heart attack). All the medicines we checked were in date and stored securely. There was no method to routinely check that emergency equipment or medicines would remain fit for use but we found evidence of an out of date refrigerated medicine having been removed in June 2017.

The practice had a business continuity plan in place for major incidents such as power failure or building damage and a buddying arrangement with another local GP. The plan included emergency contact numbers for staff but was not adequately tailored to maintain operational effectiveness at the practice. For example, the plan described scenarios of GP incapacity in terms of a partnership arrangement with salaried GPs but the provider was an individual and there were no salaried GPs. There were no formal arrangements for cover in the event of non-clinical staff illness except that staff contact and cover each other. The contact details for the practice nurse were not listed and they were not included in staffing contingency plans. A member of staff had created an initial and rudimentary template for business continuity for when the lead GP was on holiday, it included who would read and deal with hospital enquiries, immunisations and visits to the local care home for older people and been implemented.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

We first inspected the practice under the current Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on 29 June 2016. At that inspection we rated the practice as inadequate for providing effective services in respect of arrangements for delivering care in line with evidence based guidance, lack of staff appraisal and quality improvement to drive quality improvement, requirements for patient's informed consent not being met, minimal management with other providers of health and social care, a lack of staff training, gaps in arrangements for vulnerable patients after hospital attendance or admission, gaps in practice nursing cover, no failsafe systems to ensure results were received for all samples sent for the cervical screening programme.

At our follow up inspection on 22 March 2017, we rated the practice as inadequate for providing effective services in respect of lack of clinical quality improvement activity, staff cover in key roles such as practice nursing, reception staffing and chaperones. There were no staff rotas or records of staff induction and gaps or weaknesses in arrangements for staff training and patient's confidentiality. A local care home the practice provided GP services to told us the practice offered little or no GP participation in end of life and advance care planning. Systems for signposting patients that were carers were limited to chargeable products and services leaflets in the reception area. The practice could not adequately demonstrate how they encouraged uptake of the screening programme because all GPs were male and the female practice nurse sample takers attendance was seldom or could not be established. There were no failsafe systems to ensure results were received for all samples sent for the cervical screening programme and associated exception reporting was high. Cancer data obtained from Public Health England for the period 2015-2016 showed performance for females cancer screening was below local and national averages.

At this inspection insufficient improvements had been made and systemic weaknesses remained, the practice is rated as inadequate for effective services and improvements must be made.

Effective needs assessment

The lead GP was aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 91% and national average of 95%. Exception reporting was 5% compared with the CCG average of 5% and national average of 6%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 1 April 2015 to 31 March 2016 showed the practice was a positive outlier and above average for the clinical targets:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading was 140/80 mmHg or less was 93% compared to 80% within the CCG and 78% nationally. The overall exception reporting rate for diabetes was 3% compared to 7% in the CCG and 12% nationally.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded was 100% compared to 89% within the CCG and 90% nationally. The overall exception reporting rate for mental health was 5% compared to 8% in the CCG and 11% nationally.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale was

100% compared to 87% within the CCG and 90% nationally. The overall exception reporting rate for COPD was 13% compared to 11% in the CCG and 13% nationally.
- Data from 1 July 2015 to 30 June 2016 showed the average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 0.35 compared to 0.47 within the CCG and 0.98 nationally.

The practice was not an outlier for any other QOF (or other national) clinical targets. Further data from 2015 – 2016 showed:

- Performance for diabetes related indicators was similar to national averages. For example, the percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c (blood sugar level) was 64 mmol/mol or less in the preceding 12 months was 84%, compared with the CCG average of 72% and national average of 78%.
- The percentage of patients with hypertension having regular blood pressure tests was 87%, which is similar to the CCG 82% average of and national average of 83%. The overall exception reporting rate for hypertension was 2% compared to 3% in the CCG and 4% nationally.
- Performance for mental health related indicators was similar to the local and national average. For example, the percentage of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 94% compared with a CCG average of 84% and national average of 87%. The overall exception reporting rate for mental health was 5% compared to 8% in the CCG and 11% nationally.

There was no evidence of clinical quality improvement. The practice had undertaken two single cycle clinical audits and the lead GP told us one of the audits was an on-going project. There was no evidence of any other quality improvement activity but we noted the prescribing rate for some antibiotics had fallen which represented an improvement.

Effective staffing

Evidence reviewed generally showed that staff had the skills and knowledge to deliver effective care and treatment but staff cover was limited in key roles.

- There was no clear system in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff cover arrangements were informal and unknown which posed a risk to delivering safe and effective care and treatment such as cervical screening. The lead GP told us there were two female practice nurses providing ad hoc cover to undertake cervical screening.
- There were no staff rotas for planning or check back purposes, or records of staff turnover or absence such as sickness or staff management procedures. Some staff roles and working hours could be accurately determined including practice nursing and summariser. GPs were all male staff told us they did not undertake cervical screening, this meant cervical screening services for women were only available when a practice nurse may or may not be available which was indeterminate and seldom. One practice nurse was not available at least until September 2017 and there was no future date for when a practice nurse would be on duty. Evidence showed there had been no practice nurse in attendance during April 2017 and May 2017 and a practice nurse once on 6 June 2017 which was the most recent occasion.
- Reception staffing levels were limited to one staff member on the reception desk at any one time. Apart from the nurse, reception staff were the only available chaperone or female staff on duty. Staff were aware of their regular rotas and told us if they were required to chaperone they would lock the reception area and temporarily leave it without cover.
- There was no practice manager role and according to the organisational chart this role was shared between three staff including the lead GP. However there was no list of delegated duties and arrangements were not clear or effective. For example, a member of staff that was recorded as authoring or approving various procedures and being responsible for their review told us had not been involved in the process and had no knowledge of it. On the day of inspection a member of reception staff was expected on duty at 4pm but did not arrive, staff present stayed on to cover but were unaware of the reason the absent staff member had not attended.
- The practice had an induction programme for all newly appointed staff. This covered such topics as

Inadequate

Are services effective?

(for example, treatment is effective)

safeguarding, infection prevention and control, fire safety, health and safety and confidentiality but there was no record of induction for a practice nurse that the lead GP told us started in December 2016.

- Staff taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines had not received specific training which had included an assessment of competence, but could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by referring to a printout of the latest online updates.
- Practice nurses had not received an appraisal or clinical supervision but we were told they were employed at other practices. The learning needs of staff were otherwise identified through a system of appraisal. Staff had access to appropriate training to meet their learning needs and all except one had received basic life support and safeguarding training. There was no evidence of coaching and mentoring or clinical supervision for locum GPs.
- Staff received training that included safeguarding and fire safety awareness. There were no trained designated fire marshalls but staff had access to and made use of e-learning training modules and in-house training.
- Confidentiality was covered in the staff contract however no clinician files had a contract or locum agreement in place. Only one staff member had received information governance training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

There was some evidence 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. However, at our previous inspection a local care home the practice provided GP services to told us the practice offered little or no GP participation in end of life and advance care planning and at this inspection reported little improvement.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. 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. However, we also found 34 patients on the palliative care register that had mostly been wrongly coded and needing palliative care such as at the end of life.

Patients were signposted to the relevant service but systems for signposting carers were limited to product sales leaflets in the reception area. There was a also a lack of clarity for coding arrangements to identify patients that were carers. The code non-clinical staff used did not show any carers registered at the practice, but the clinical staff search showed the practice had identified 34 patients as carers.

Inadequate

Are services effective?

(for example, treatment is effective)

There were leaflets in the reception area encouraging patients to attend national screening programmes for bowel and breast cancer screening.

The practice's uptake for the cervical screening programme was 87%, which was comparable to the CCG average of 78% and the national average of 81%. However, exception reporting was relatively high at 26% compared to 11% within the CCG and 7% nationally. Locally held data showed 79% uptake for the cervical screening programme that represented 1 April 2017 to 3 July 2017 inclusive.

We looked at cervical screening in more detail as this issue had also been of concern at our previous inspections and a check that showed 11 test samples obtained and sent to the laboratory for screening had not been received since 1 March 2017. Staff showed us evidence they had chased up four results the day after previous inspection 23 March 2017 and the lead GP told us results from a local hospital had been delayed. We ran a longer term check and found over the last 10 years there were 49 test samples sent that were never received. We checked for a failsafe system and found there was one in place but it was not effective. For example, there was a lack of follow up for delayed results and an "inadequate" result that was received by the provider early April 2017, which means the test was unreadable and patients usually are called for a repeat cervical cytology sample in three months, but there was no indication this follow up action had been assured.

There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test but the practice could not adequately demonstrate how they encouraged uptake of the screening programme because all GPs were male and female practice nurse sample takers attendance was seldom or could not be established.

At our previous inspection we suggested the practice seek to understand and improve performance for female patient's breast cancer, as data obtained from Public Health England for the period 2015-2016 showed performance for female care such as cancer screening was below both local and national averages, compared to data for bowel cancer that was similar to local averages but below the national average:

- Females aged 50-70, screened for breast cancer in last 36 months was 51% compared to 59% within the CCG and 73% nationally.
- Females aged 50-70, screened for breast cancer within 6 months of invitation was 0% compared to 63% within the CCG and 74% nationally.
- Persons aged 60-69, screened for bowel cancer in last 30 months was 48% compared to 43% within the CCG and 58% nationally.
- Persons aged 60-69, screened for bowel cancer within 6 months of invitation was 40% compared to 37% within the CCG and 56% nationally.

Also at our previous inspection we noted a letter dated 7 March 2017 the practice had sent to patients urging them to respond the same day for one of two dates for a cervical screening test that offered only two future date options in the near future and indicated an alternative option for patients was to refuse the test or choose to have their name removed or suspended from the cervical screening list. The letter also indicated the service would be restored later in the year but with no indication as to when, it explained the purpose of the smear including "it is important that you make the choice as it would give you mental peace that your womb is clear of cancer" but did not provide any certainty, clarity or continuity about future arrangements for the national cervical screening program that is a vital cancer prevention service for women.

At this inspection, the lead GP told us the practice population was diverse and less likely to accept the offer of a cervical screening test, but this did not explain the deviation from local averages whose population was similar.

Childhood immunisation rates for under two year olds were 94%, (the national expected coverage of vaccinations is 90%); and the Measles, Mumps and Rubella (MMR) vaccine for five year olds was 100% for Dose 1 compared to 94% nationally; and 100% for Dose 2 compared to 88% nationally.

Inadequate

Are services caring?

Our findings

We first inspected the practice under the current Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on 29 June 2016. At that inspection we rated we rated the practice as requires improvement for providing caring services as the practice premises and equipment were visibly dirty. Interpretation services were not advertised and staff were unclear how to access the service for patients needing it.

At our follow up inspection on 22 March 2017, we rated the practice as requires improvement for providing caring services as previous issues such as had not been sufficiently addressed such as practice premises and equipment being visibly dirty and issues regarding accessibility to services for patients requiring interpretation. GP patient survey satisfaction scores for caring services were comparable to CCG averages but below national averages and these results had not been explored further and no changes had been proposed or made in response. We also suggested the practice should review systems for signposting carers and embed polices and guidance.

At this inspection, improvement was limited to aspects of accessibility to services for patients requiring interpretation. Remaining previous issues were not sufficiently addressed and the practice is rated as inadequate for caring services.

Kindness, dignity, 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.
- Female patients could rarely be treated by a clinician of the same sex.

The four patients we spoke to said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

Results from the national GP patient survey published July 2017 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores regarding receptionists and generally slightly below national averages for its satisfaction scores on consultations with GPs. For example:

- 83% said the GP was good at listening to them compared to the CCG average of 82% and the national average of 89%.
- 73% said the GP gave them enough time compared to the CCG average of 78% and the national average of 86%.
- 90% said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and the national average of 95%.
- 67% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 77% and the national average of 86%.
- 92% said they found the receptionists at the practice helpful compared to the CCG average of 78% and the national average of 87%.

There was no available 2017 GP Patient survey data for nurses. GP patient survey published July 2016 regarding nurses showed:

- 86% of patients said last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 86% and the national average of 92%.
- 84% of patients said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 83% and the national average of 91%.
- 83% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 82% and the national average of 90%.

Most GP patient survey satisfaction scores data on consultations with GPs was lower than in 2016.

Other evidence showed little or no improvement since our previous inspection. For example, the manager of a local care homes where some of the practice's patients lived told us there was a very small improvement but problems with obtaining prescriptions for resident's nutrition supplements and dressings and monthly electronic prescriptions administrative issues remained.

Inadequate

Are services caring?

Results and feedback had not been explored further and no changes had been proposed or made in response to the national GP patient survey results. We noted the practice had recorded 100% positive feedback on the friends and family test during April 2017 and May 2017.

At our previous inspection the practice showed us evidence it had undertaken its own survey of 35 patients in March 2016 and found all feedback was positive. The action plan stated there were no concerns and a further survey was to be conducted in June 2017. At this inspection we found no follow up survey had been carried out.

Care planning and 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. We also saw that care plans were personalised.

Results from the national GP patient survey showed satisfaction relating to questions about their involvement in planning and making decisions about their care and treatment were slightly below or below averages. For example:

- 68% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79% and the national average of 86%.
- 64% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 74% and the national average of 82%.
- There was no data available for survey results on whether practice nurse was good at involving patients in decisions about their care.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpreter 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. At our previous inspection we saw a multi lingual check in screen had no hand sanitiser to minimise the risk of cross infection and was not functional because it was not connected to the appointment system. At this inspection, the main multi lingual check in screen worked but the secondary one next to the blood pressure monitoring machine did not and there was no hand sanitiser in the reception area.
- 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 and carer support to cope emotionally with care and treatment

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. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services. The practice did not have a website. At our previous inspection we suggested the provider should review arrangements for patient's access to information and services online.

The practice's computer system alerted GPs if a patient was also a carer. The code non-clinical staff used did not show any carers registered at the practice, but the clinical staff search showed the practice had identified 34 patients as carers (2.5% of the practice list). Carers were invited to attend for a flu vaccine and included in care planning discussions at multidisciplinary meetings. Written information available to support carers was limited to products information, we found no support information in the practice reception area such as for a local carers group.

Staff told us that if families had suffered bereavement, the lead GP contacted them. 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.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We first inspected the practice under the current Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on 29 June 2016. At that inspection we rated the practice as requires improvement for providing responsive services in respect of complaints management such as no evidence lessons were learned from concerns and complaints, and due to concerns regarding premises.

At our follow up inspection on 22 March 2017 we were unable to re-evaluate complaints management as staff told us there had not been any complaints in the past 12 months and we kept complaints management under review. Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above local and national averages and we rated the practice as good for providing responsive services

At this inspection, we noted the practice reported not receiving any complaints either written verbal since our previous inspection, and re-evaluated the question of whether services are responsive to people's needs. There was evidence the provider had not listened to or learned from concerns or complaints or shared relevant information with CQC as required. The practice is rated inadequate for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had generally used this understanding to meet the needs of its population:

- The practice offered extended hours from 6.30pm until 7.00pm on Tuesdays and Fridays for working patients who could not attend during normal opening hours but closed weekly on Thursday afternoon.
- 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.
- GPs provided a visiting doctors round to residents at a 60 bedded local care home. Feedback from the care home was not positive and indicated on-going concerns with limited improvement since our previous inspection, including insufficient practice management, delayed repeat prescribing for dressings and food supplements, a lack of end of life and advance care planning, and a lack of communication including with residents families in relation to medicines.
- 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 and were referred to other clinics for vaccines available privately. There were accessible facilities, which included a hearing loop, and interpretation services available.
- Baby changing facilities and a private room for breastfeeding were available.
- The practice provision of some services was absent or limited such there being no ear irrigation or phlebotomy and cervical screening services were limited and had not been available April to June 2017 inclusive, due to lack of female clinical staff.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 9.00am to 11.00am and 4.00pm to 6.00pm except Thursdays when appointments finished after morning surgery but the practice doors remained open. Extended hours GP appointments were offered from 6.30pm until 7.00pm on Tuesdays and Fridays. Patients telephoning when the practice was closed were directed to the local Newham GP Co-op out-of-hours service provider. Appointments included pre-bookable appointments, home visits, telephone consultations and urgent appointments for patients who need them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were comparable to or above local and national averages.

- 87% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and the national average of 76%.
- 93% found it easy to get through to this surgery by phone which was comparable to the CCG average of 56% and the national average of 71%.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 90% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 73% and the national average of 84%.
- 89% of patients said their last appointment was convenient compared with the CCG average of 67% and the national average of 81%.
- 86% of patients described their experience of making an appointment as good compared with the CCG average of 62% and the national average of 73%.
- 54% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 41% and the national average of 58%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

For example, by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Staff told us there had been no written or verbal complaints in the last 12 months which was the same as at our previous inspection 22 March 2017 and totalled more than 15 months where the practice had not noted any kind of complaint from a patient. For a provider to not receive any complaints over an extended period of time is unusual and could indicate a number of considerations that warranted further inspection. We looked at how the provider listened to and learned from complaints or concerns in further detail.

- The practices complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The lead GP was the designated responsible person for handling all complaints in the practice. We saw that information was available to help patients understand the complaints system. For example a complaints poster and leaflets in the reception area.

There were no recorded complaints or evidence of lessons learned from individual concerns and complaints or analysis of trends or of action was taken to improve the quality of care.

We contacted external organisations such as NHS England, Newham CCG and Healthwatch that patients sometimes convey feedback to for any complaints or concerns they had received, and whether it had been shared with the practice. Information showed there were complaints including at least one in the past year the practice had been involved in investigating and responding to that was recorded as upheld. However, the practice had not disclosed this information to the CQC.

We also checked patient's feedback on the NHS choices website that showed an average score of 1.5 out of five stars, the two comments within the preceding year gave the provider a one star rating and the provider had not responded to any of the NHS Choices comments.

Are services well-led?

Inadequate

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

Our findings

We first inspected the practice under the current Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on 29 June 2016. At that inspection we rated the practice as inadequate for providing well-led services as there was no vision or strategy for the practice, overarching governance structure or clear leadership or management arrangements. Staff were not clear about their responsibilities and there were gaps in staff training, performance reviews (appraisals) and team and organisational objectives setting. Policies were not reviewed or fit for purpose, arrangements for patient confidentiality were ineffective, and there was no evidence of a quality improvement process

At our follow up inspection on 22 March 2017, we rated the practice as inadequate for providing well-led services for reasons including the vision and strategy were unclear and there were no business plans. The delivery of high quality care was not assured by the leadership, governance or culture of the practice. The lead GP was the decision maker and lead for every aspect of strategic and managerial work, and operational and clinical services delivery. The lead GP identified the main challenges to good quality care as workload and staffing including in their absence from work and the arrangements were unclear. Some staff expressed concerns about the lead GP being lead for everything. There was evidence of improvements being made but sustainable arrangements for safety and other fundamental areas such as staffing remained ineffective or had not been satisfactorily addressed. Operational structures did not provide an effective framework for delivery of safe or effective care, risks had not been managed and there was no evidence of learning or quality improvement activity.

At this inspection sufficient improvement had not been made such as there was no method to deliver sustainable improvement, there continued to be multiple breaches of legislation for over a year and the provider had not addressed the serious concerns raised and had failed to act on past risks. The practice is rated as inadequate for well-led services.

Vision and strategy

- There was an unwritten mission statement, staff were not aware of it but demonstrated their values were to be caring and put patients first.
- The forward vision and strategy was unclear and there were no business plans.

Governance arrangements

The practice governance framework did not support the delivery of safe or effective care:

- There were systemic weaknesses in governance systems such as ineffective monitoring or improvement of quality and safety through safety alerts response, significant events identification and management, and two cycle clinical audit (or other clinical improvement activity).
- There were no staff rotas, some staffing arrangements were absent or indeterminate and there was insufficient cover of practice nursing or female clinicians. There was no evidence of the provider attempting to recruit a regular female clinician or carrying out assessments or monitoring to improve important data for female's clinical care that remained below average. Informal arrangements were inadequate and had continued to result in risks to patient safety, for example cervical screening.
- Relevant information had not been organised or maintained for staff including DBS checks, medical indemnity cover and staff immunisation status. We wrote to the provider under Section 64 of the Health and Social Care Act 2008 (Section 64 gives the Care Quality Commission the legal power to require certain persons to provide it with information, documents, records or other items that the CQC considers it necessary or expedient to have for the purposes of its regulatory functions) to obtain evidence of relevant staff medical indemnity and immunity status and the information we received demonstrated significant gaps.
- Reception staff were aware of their own roles and responsibilities and told us the lead GP was responsible for all areas including complaints, infection control, and safeguarding. However, arrangements for practice management and for in the absence of the lead GP were ineffective. For example, the business continuity plan required staff to cover that were not employed or available within the practice, staff that were named as having responsibilities according to documents such as policy or procedure had not been involved in the

Are services well-led?

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process and had no knowledge of it. The lead GP had sent an email to local colleagues at the end of June 2017 to recruit a part time practice manager but no formal recruitment process had taken place and the actions were insufficient and delayed.

- The organisational structure was inoperable, for example there were three staff delegated to cover the practice manager role, one had not been at the practice for a period of at least three months and was not due to return for the foreseeable future and the other was not aware of their practice manager role responsibilities. The organisational chart did not include detail of delegated responsibility to ensure specific tasks such as checking emergency equipment or other responsibilities would be completed.
- There were gaps in basic arrangements such as ensuring security of areas that resulted in risks to patients. An important set of keys had not been available to secure several of these areas for a substantial period, one staff member told us the keys were missing for two weeks and another reported. After inspection the provider told us the keys were found pushed back behind a file but had since been moved to be kept safely with other keys.
- Medicines and other items were expired, not safety checked or checks were not followed up throughout the practice. It appeared most clinical equipment was calibrated but there was no inventory of clinical equipment to ensure this and we found items that had not been calibrated.
- An overview understanding of the performance of the practice was maintained but this was limited to being as a result of our inspections and other external professional's visits such as infection control audits and resulting action plans had not been followed up.
- Confidentiality was covered in the staff contract but no clinician's files had a contract or locum agreement in place. Some staff were registered as patients and there was no system in place to assure confidentiality of their medical records within the staffing team.

Leadership and culture

The provider did not demonstrate they had the experience or knowledge and skill to run the practice and ensure high quality care. For example, we raised the issue of multiple thermometers in the medicines refrigerator and the providers response did not indicate they understood basic aspects of how the refrigerator worked. Similarly when we brought the issue of a fire door being deadlocked the Lead GP did not convey due diligence or insight.

There were other areas of concern including a pattern of the practice not providing accurate information to the CQC. For example, at previous inspections the provider stated it had not received an Infection Control action plan, but this was not the case. At this inspection the provider said it had not received a report from an NHS England medical directorate review of the practice, but this was also not the case. The provider did not ensure that their CQC rating(s) were displayed conspicuously and legibly at the location delivering a regulated service and had not updated its registration with the CQC as required for more than a year.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). However, there was no evidence of support training for all staff on communicating with patients about notifiable safety incidents. The practice no examples but had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

The practice held minuted multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs liaised with allied health and social care professionals to monitor vulnerable families and safeguarding concerns.

- Staff told us staff meetings were ad hoc and not minuted. No formal meetings had taken place since our previous inspection. The Lead GP told us there had been a meeting in February 2017 that had not yet been minuted. There was no structure to facilitate agreement of actions or to follow up.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. No team away days or social events were held.

Are services well-led?

Inadequate

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- Staff said they felt respected, valued and supported by the lead GP. Staff were not involved in discussions about how to run and develop the practice or engaged to identify opportunities to improve the service but said they were able to make suggestions which would be considered by the lead GP.

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

There was no evidence of a process for quality improvement. However, the practice encouraged and valued feedback from patients through the patient participation group (PPG)

- The practice had met with the patient participation group (PPG) and gathered feedback from patients through surveys. The Patient Participation Group (PPG) met every three months, staff told us most recently a few days before our inspection but there was no evidence of a process for quality improvement.
- We found no evidence the practice had gathered feedback from staff but staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services 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 registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Testing and monitoring clinical results for patients, dangers or hazards in patient accessible areas, fire safety arrangements and business continuity plans. The equipment being used to care for and treat service users was not safe for use. In particular: • Electrical and clinical equipment, expired clinical items in both clinical and non-clinical areas. Arrangements for the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated were ineffective. There was no proper and safe management of medicines. In particular: • Refrigerated and expired medicines. 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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met:** The registered person had failed to ensure that all premises used by the service were secure. In particular:

This section is primarily information for the provider

Enforcement actions

- Keys to secure it had been missing for some time and could not be found.

The registered person had failed to ensure that all premises and equipment used by the service were suitable for the purpose for which they are being used. In particular:

- Fire exit was deadlocked, lack of fire action signage, long pile carpets that were a trip hazard, peak flow meters, and examination couch

The registered person had failed to ensure that all premises and equipment used by the service were secure. In particular:

- Accessible areas with open wires, boiler, clinical waste bin.

The registered person had failed to ensure that all equipment used by the service was properly used. In particular:

- Clinical trolleys and fire blanket.

The registered person had failed to ensure that all premises used by the service were properly maintained. In particular:

- Premises decoration or refurbishment.

The registered person had failed to maintain standards of hygiene appropriate for the purposes for which the premises were being used. In particular:

- Carpets, premises and equipment.

This was in breach of regulation 15(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Family planning services	**How the regulation was not being met**
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Enforcement actions

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Safety alerts, identify and address day to day risks / opportunities to improve, services provided to a local care home, female patients cancer screening.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Significant events, staff meetings, staff duties unclear, system to ensure electrical or clinical equipment remained fit for use, to ensure medicines and equipment including for the event of an emergency availability or fitness for use, for planning and monitoring the number of staff and mix of staff needed to meet patients' needs, for clinical quality improvement, to ensure patients are correctly coded

There were no systems or processes that enabled 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:

- Arrangements to regularly review the immunisation status of relevant staff and providing vaccinations to staff as necessary in line with Immunisation against infectious diseases requirements.

There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Arrangements for patient's confidentiality.

There were no systems or processes that ensured the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- System to ensure staff files complete.

This section is primarily information for the provider

Enforcement actions

This was in breach of regulation 17(1) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • Induction, appraisal, information governance and fire marshal. This was in breach of regulation 18(2) 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person's did not ensure relevant information was available or ensure that only persons of good character were employed as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular: • References and DBS checks, appropriate indemnity as enshrined in the GMC's 'Good medical practice', and as of 16 July 2014 this became a legal requirement under the Health Care and Associated Professions (Indemnity Arrangements) Order 2014. This was in breach of Regulation 19 (3)(a)(b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.