Dr Shada Parveen

Quality Report

The Maybury Surgery
Woking
Surrey
GU22 8HF
Tel: 01843728757
Website: www.mayburysurgery.co.uk

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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 well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Shada Parveen (The Maybury Surgery) on 15 November 2016. The overall rating for the practice was inadequate. The full comprehensive report on the November 2016 inspection can be found by selecting the 'all reports' link for Dr Shada Parveen on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 27 April 2017 to confirm that the practice was compliant with warning notices issued following the November 2016 inspection. The warning notices were issued against regulation 12 (1) (safe care and treatment), regulation 17 (1) (good governance) and regulation 19 (1) and (2), 19 (3) and (4) (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report covers our findings in relation to those requirements. The ratings remain unchanged from the November 2016 inspection as the purpose of the April 2017 inspection was to review compliance against the warning notices issued.

Our key findings were as follows:

- The practice had made improvements to recruitment processes and we saw that appropriate employment checks had been carried out on staff including references, identification checks and Disclosure and Barring Service (DBS) checks.
- There was evidence of improvements made to incident reporting, discussion and learning.
- Clinical equipment had been tested to ensure it was working properly.
- The practice had developed a system to ensure that vaccines were in date and fit for use, they had carried out a clinical audit of vaccines used across a six month period to ensure that no out of date vaccines had been administered.
- Printer prescriptions were now locked away when not in use and there was a prescription tracking system in use in the practice.

Summary of findings

- The practice was developing a programme of clinical audit and had identified ways to improve patient outcomes in relation to the management of long term conditions, specifically in relation to diabetes care.
- The practice had taken action to improve infection control practices including identifying clear leadership and carrying out an infection control audit. However, not all staff had received infection control training and two of three sharps bins in the practice had not been labelled appropriately.
- The practice had taken action to improve communication, including holding regular staff meetings.
- The practice had re-engaged with the patient participation group (PPG) and had held one meeting with another one planned.

  However, there were also areas of practice where the provider needs to make improvements.
- There continued to be some gaps in risk management with areas of potential risk not adequately mitigated through the use of risk assessments including control of substances hazardous to health (COSHH) and the security of the premises. Fire safety and defibrillator risk assessments had been carried out, however these did not always identify the specific risks or adequately mitigate them.
- There was a system in place to review and update practice policies, however the information contained in the reviewed policies was seen to be out of date in some cases and not all staff had signed to say they had read and understood them.

Importantly, the provider must:

- Ensure that all environmental risks are identified through a process of risk assessments where all risks are clearly and adequately mitigated.
- Ensure that policies are comprehensively reviewed and that information contained in them is current and relevant and that all staff have read and understood them.

In addition the provider should:

- Ensure that sharps bins are appropriately labelled.
- Ensure that all staff attend infection control training that is relevant to their role.

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 

In November 2016 the practice was rated as inadequate for providing safe services and we told them that improvements must be made. Warning notices were issued because patients were at risk of harm because systems and processes were not in place in a way to keep them safe. There was evidence of incident reporting, however investigations, discussions and learning were inconsistent and records were insufficient. There was no infection control lead, completed audit or risk assessment in place. Clinical equipment had not been calibrated. There were out of date vaccines and medicines were not appropriately managed. There was no system to monitor the use of blank prescriptions and prescriptions stored in printers were not stored securely. Recruitment checks were not consistently undertaken in line with the practice policy and checks of locum staff were not carried out. Disclosure and Barring Service (DBS) checks were not carried out and the practice was reliant on historical checks when taking on new staff. Environmental risks were not routinely assessed in relation to fire, health and safety or security within the practice.

In April 2017 we saw that improvements had been made to the way incidents were reviewed and discussed and there was evidence of learning and improvements as a result. There was clear infection control leadership and a risk assessment had been carried out with clear action taken in relation to replacing privacy curtains with disposable ones and ensuring that the appropriate range of sharps bins were available. However, not all staff had yet completed infection control training and not all sharps bins were correctly labelled. Vaccines stored within the practice were all in date and the practice had undertaken audits of all vaccines to ensure that no patient had received an out of date vaccine following the identification of out of date vaccines at the November 2016 inspection. Recruitment checks had been appropriately undertaken with improvements seen in relation to the receipt of satisfactory references and appropriate identification checks. DBS checks had been carried out on all staff since the November 2016 inspection. Some efforts had been made to undertake appropriate environmental risk assessments; however the risks had not all been identified or appropriately mitigated.

Summary of findings

Are services effective?

Inadequate

At our previous inspection on 15 November, we rated the practice as inadequate for providing effective services as there were areas that needed improving. Clinical audits had been carried out, however these were not completed full cycle audits.

On 27 April 2017 we saw that repeat cycle audits had not yet been undertaken, however clear action had been taken to improve outcomes for patients and further audit cycles were planned. This included contacting all patients with poorly controlled diabetes and offering them a diabetes review or further information about their diabetes. The practice was also in the process of recruiting to a nurse practitioner post with the aim of improving the care of patients with long term conditions. They were also in the process of liaising with external services to provide health promotion sessions at the practice to improve the care of patients with diabetes.

Are services well-led?

Inadequate

In November 2016 we found that the practice had a number of policies and procedures to govern activity, but in some cases these were over five years old and had not been reviewed since. The practice did not hold regular governance meetings and held discussions on an ad hoc basis where records were not maintained. Risks were not consistently identified or managed. Learning from significant events and complaints was not evident. The practice had not proactively sought feedback from patients and did not have a patient participation group (PPG).

During out April 2017 inspection we found that the practice had made some improvements to their policy and procedures. They had begun a process of review, however even in some of those policies that were recorded as having been reviewed there were some aspects that were out of date. The management of the practice had taken some action to improve the assessment and management of risks, however there continued to be some gaps in this area where risks had not been identified or adequately mitigated. Learning from significant events was evident in the recorded discussions at team meetings although records relating to the one complaint received since the previous inspection were limited. The practice had engaged with the PPG and had carried out one PPG meeting with another one planned for May 2017.

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

At the November 2016 inspection we identified concerns in safe, effective, caring and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The April 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the November 2016 inspection. The ratings for the practice and this population group were not reviewed as part of the April 2017 inspection.

Inadequate

People with long term conditions

At the November 2016 inspection we identified concerns in safe, effective, caring and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The April 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the November 2016 inspection. The ratings for the practice and this population group were not reviewed as part of the April 2017 inspection.

Inadequate

Families, children and young people

At the November 2016 inspection we identified concerns in safe, effective, caring and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The April 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the November 2016 inspection. The ratings for the practice and this population group were not reviewed as part of the April 2017 inspection.

Inadequate

Working age people (including those recently retired and students)

At the November 2016 inspection we identified concerns in safe, effective, caring and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The April 2017 inspection was a focused follow up

Inadequate

Summary of findings

inspection to review the provider's compliance against warning notices issued following the November 2016 inspection. The ratings for the practice and this population group were not reviewed as part of the April 2017 inspection.

People whose circumstances may make them vulnerable

Inadequate

At the November 2016 inspection we identified concerns in safe, effective, caring and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The April 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the November 2016 inspection. The ratings for the practice and this population group were not reviewed as part of the April 2017 inspection.

People experiencing poor mental health (including people with dementia)

Inadequate

At the November 2016 inspection we identified concerns in safe, effective, caring and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The April 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the November 2016 inspection. The ratings for the practice and this population group were not reviewed as part of the April 2017 inspection.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure that all environmental risks are identified through a process of risk assessments where all risks are clearly and adequately mitigated.
- Ensure that policies are comprehensively reviewed and that information contained in them is current and relevant and that all staff have read and understood them.

Action the service SHOULD take to improve

- Ensure that sharps bins are correctly labelled.
- Ensure that all staff complete infection control training that is relevant to their role.

Dr Shada Parveen

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included an additional CQC inspector.

Background to Dr Shada Parveen

Dr Shada Parveen offers general medical services to people living and working in Woking. The practice population has a significantly higher than average proportion of working patients and also patients that are unemployed. There is a higher proportion of children under the age of 18 and a below average proportion of older patients. There is higher deprivation affecting older people and children. The practice population has a high proportion of Asian and Eastern European patients. The practice is placed in the sixth least deprived decile.

The practice holds a General Medical Service contract and is led by one female GP. At the time of this inspection the GP providing the service is different from the GP registered with CQC as the provider. We were told that the practice was going through a change of management. The GP is supported by a locum GP (male), a locum practice nurse, a healthcare assistant, a practice manager, a compliance manager and a team of reception and administrative staff. A range of services are offered by the practice including asthma reviews, child immunisations, diabetes reviews, new patient checks, and smoking cessation.

The practice was open between 8.30am and 6.30pm Monday to Friday. Between 8am and 8.30am access to the practice was through an out of hour's provider (Care UK). The practice runs a drop in service two mornings a week on a Tuesday and Thursday. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider (111/Care UK).

Services are provided from:

The Maybury Surgery,

Woking,

Surrey

GU22 8HF

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Shada Parveen on 15 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate. The full comprehensive report following the inspection on 15 November 2016 can be found by selecting the 'all reports' link for Dr Shada Parveen on our website at www.cqc.org.uk.

We undertook a follow up warning notice focused inspection of Dr Shada Parveen on 27 April 2017. This inspection was carried out to review compliance and action taken by the practice against warning notices issued in relation to Regulation 12, Regulation 17 and Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to confirm that the practice was now meeting legal requirements.

Detailed findings

How we carried out this inspection

We carried out a warning notice focused inspection of Dr Shada Parveen on 27 April 2017. During our visit we:

- Spoke with a range of staff (a GP, compliance manager, practice manager and reception staff).
- Reviewed records relating to how the practice was run including risk assessments, policies, meeting minutes and clinical audits.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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

At our previous inspection on 15 November 2016, we rated the practice as inadequate for providing safe services as; the arrangements in respect of cleanliness and infection control were not adequate; medicines were not appropriately managed, recruitment checks and records were not maintained, risks were not adequately identified and managed, significant events and safety incidents were not adequately managed and clinical equipment was not adequately maintained to ensure it was working properly.

Safe track record and learning

During our inspection on 15 November 2016 we found that safety incidents were not always recorded with clear actions, there were no records of significant event discussions with staff and there was no evidence of the identification of themes, trends and lessons learnt.

During our follow up inspection on 27 April 2017 we found that significant events and near misses were recorded and there was some evidence of discussion at team meetings and involvement of staff in actions and learning outcomes. This was an improvement since the previous inspection. Actions relating to significant events had not been reviewed and there were some significant events recorded electronically that were not included in the paper file; however the new system had only been in use for a few weeks.

Overview of safety systems and process

During our inspection on 15 November 2016 we found that the practice had some systems, processes and practices in place to keep patients safe. However, there were issues relating to cleanliness and infection control, medicines management and recruitment checks:

- On 15 November 2016 we found that the practice did not have a process for ensuring that all staff who acted as a chaperone had received a Disclosure and Barring Service (DBS) check. There was no risk assessment in place for staff relating to DBS checks and those staff who did have a record of a check had received these some years prior to commencing in post. On 27 April 2017, we found that all staff working in the practice had been subject to a DBS check in the past few months.
- On 15 November 2015 we found that appropriate recruitment checks had not been undertaken prior to employment and in line with the practice policy. There were gaps in checks in some staff files, for example references had not been checked for three out of four staff and two of the four did not have evidence held of proof of identification. In addition there were no records of relevant recruitment checks held for locum GPs. On 27 April 2017, we viewed three personnel files and saw that references had been obtained for all three including previous employment references and that there was evidence of photographic identification checks. We also viewed the file of one locum GP and found that as well as a locum contract in place, there was evidence of DBS checks, references and GMC (General Medical Council) registration checks.
- On 15 November 2016 we found that some infection control processes within the practice were unclear, there was no record of the laundering of privacy curtains, there was one incomplete infection control audit on file, staff were uncertain of who had responsibility for the leadership of infection control and the expected range of waste bins for the disposal of sharps was not available. On 27 April 2017 we found that an infection control audit had been completed on 19 April 2017. Specific action taken to improve infection control processes within the practice included that privacy curtains had been changed to disposable and had clear dates recorded on them for when they were due to be replaced. In addition there was clear clinical and non-clinical leadership and we saw that a full range of sharps disposal bins were available. However, two of the three sharps bins in use at the time of inspection were not appropriately labelled and not all staff had attended infection control training.
- On 15 November 2016 we saw that while the temperature of the vaccine fridge was monitored on a daily basis, the practice did not have a clear policy in place relating to what staff should do if the fridge temperature was outside of the range at which vaccines were required to be stored. We also found two ampoules of expired vaccine. In addition there was no system in place to monitor the use of blank prescription forms and prescriptions held in printers were not kept securely. On 27 April 2017 we found that the practice had developed a clear policy on maintaining the cold chain of the vaccines stored within the practice and a log of fridge temperatures continued to be maintained. All vaccines stored within the practice were in date and the practice had undertaken an audit of vaccines given

over the previous six months to ensure that no expired vaccines had been administered. A new system to monitor the use of prescriptions had been implemented that included the maintenance of a log of all prescriptions and where they were stored. Security of printer prescriptions had improved with all rooms locked and paper prescriptions removed when not in use.

Monitoring risks to patients

On 15 November 2016 we found that there were insufficient procedures in place for monitoring and managing risks to patient and staff safety:

- On 15 November 2016 the practice did not have a fire risk assessment in place, fire extinguishers did not include evidence of regular checks and maintenance, the practice had not carried out regular fire drills and the fire alarm system was not regularly checked to ensure it was working. On 27 April 2017 we saw that a fire risk assessment had been carried out in February 2017. However, there were aspects of the risk assessment that were incorrect. For example, it stated that there were no ignition sources, no sources of fuel and that people were not at risk. There was evidence that the practice had taken action to mitigate the risk of fire however, for example by logging weekly fire alarm checks, improving fire safety signage, ensuring fire extinguishers were maintained and by undertaking a fire evacuation drill.
- On 15 November 2016 the practice did not have records to demonstrate that all clinical equipment had been calibrated and checked to ensure it was working properly. On 27 April 2017 we saw records that demonstrated equipment had been calibrated on 20 April 2017.
- On 15 November 2016 we identified that the practice did not have a variety of risk assessments in place to monitor the safety of the premises. For example, there was no risk assessment relating to the control of substances hazardous to health (COSHH), that there was no defibrillator within the practice or to the security of the premises despite breaches to security in the past. In addition, while there was evidence of regular water testing being carried out by an external contractor, the practice did not have a copy of a risk assessment so therefore could not be assured that all action required was being taken. However, following the inspection they obtained a copy of a legionella risk assessment that had been carried out in December 2014. The compliance manager at the practice also told us at this point that they were undertaking monthly monitoring of the water temperatures although we had not seen evidence of this during inspection. On 27 April 2017 the practice had still not assessed the risks associated with the security of the premises and COSHH and did not have a copy of a legionella risk assessment. They had undertaken a risk assessment relating to not having a defibrillator within the practice; however they had not fully mitigated the risks associated with this. For example, they had not considered the time it might take for an ambulance to reach the practice in the event of an emergency.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 15 November, we rated the practice as inadequate for providing effective services as there were areas that needed improving. Clinical audits were not completed, full cycle audits.

While complete cycle audits had not been undertaken when we undertook a follow up inspection on 27 April 2017, clear action had been taken to improve outcomes for patients and further audit cycles were planned.

Management, monitoring and improving outcomes for people

- On 15 November 2016 we saw evidence of two single cycle, incomplete clinical audits. There was limited evidence that the findings were used by the practice to improve services. For example, a diabetic audit was not used to improve outcomes for patients. On 27 April 2017 we saw that in response to the identification of a high proportion of patients with poor diabetic control a number of actions had been taken. For example, the GP had engaged with a community pharmacist who attended the practice on a weekly basis to discuss patients. The GP had targeted patients with poor diabetic control and asked them to attend for a diabetic review. There was a renewed focus within the practice on quality improvement for patients with long term conditions and the practice were in the process of recruiting to a nurse practitioner role to support improved management of long term conditions. In addition the practice was in discussion with community services to provide health promotion sessions at the practice and had arranged practice based clinics with a community diabetic specialist nurse. A further diabetic audit cycle was planned.

Two further single cycle clinical audits had been carried out. One related to the use of vaccines within the practice and a re-audit was planned for May 2017, the other was an audit of the use of high risk medicines within the practice.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 15 November 2016, we rated the practice as inadequate for providing well-led services as there was no overarching governance structure to support the delivery of good quality care.

We issued a warning notice in respect of these issues and found arrangements had improved when we undertook a follow up warning notice inspection of the service on 27 April 2017.

Governance arrangements

- On 15 November 2016 we saw that practice specific policies had been implemented and were available to all staff. However, many of these appeared to be a number of years out of date, with information contained in the policies such as staff responsibilities citing staff who no longer worked at the practice. On 27 April 2017 we saw that a number of policies had been updated and that arrangements were in place to work through and update all practice policies. However, there were some areas of policies where information was out of date or inconsistent. For example an employment of offenders policy that was reviewed in March 2017 made reference to primary care trusts (PCT's) instead of clinical commissioning groups (CCG's) and to criminal records bureau (CRB) checks rather than Disclosure and Barring Service (DBS) checks. A health and safety policy made reference to the manager calling 999 in case of a fire whereas the fire safety policy states the call should be made by the person suspecting a fire. In addition, not all staff had signed to state that they had read and understood the revised policies.
- On 15 November 2016 it was identified that the practice did not have in place a programme of clinical audit to monitor quality and make improvements. On 27 April 2017 the practice had identified areas where improvements were needed and we saw evidence of the use of clinical audits to drive improvements. This was a work in progress and repeat cycle audits were planned in some areas in order to identify and demonstrate improvements made.
- On 15 November 2016 there were limited arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. On 27 April 2017 we saw that the practice had made some effort to improve the management of risks within the practice. However, this was not always comprehensive and the identification and mitigation of risk continued to be limited in some areas.
- On 15 November 2016 the processes for recording, investigating, discussing, taking action and learning from complaints and significant events were not in place. On 27 April 2017 we saw that some improvements had been made in this area. For example, significant events were recorded on a reporting form in line with practice policy. There was evidence of review and discussion and action being taken to address significant events. For example, we viewed minutes of a staff meeting dated 16 March 2017 where a significant event was discussed relating to vaccines where action included the implementation of a weekly vaccine stock check every Monday. There were a limited number of complaints received by the practice; however we viewed one complaint that had been forwarded to the practice from NHS England. We saw that the practice had written to the patient to acknowledge the complaint; however there was no written evidence of the complaint having been investigated. Staff we spoke with said that this complaint had been received during the transition from one management structure to another.
- On 15 November 2016 meetings were not recorded in the practice. Staff told us they discussed issues as a matter of routine but there was no evidence of this. On 27 April 2017 we saw minutes of staff meetings that had been held on a fortnightly basis from February 2017. We saw evidence of open communication within the practice.

Leadership and culture

- On 15 November 2016 we were told that staff felt they had the opportunity to raise any issued during discussions and felt confident and supported in doing so. However, there were limited records of staff meetings to demonstrate this. On 27 April 2017 we saw minutes of meetings were there were open discussions evident about changes and activities within the practice. The practice had set up a practice messenger group to encourage more open communication.
- On 15 November 2016 we found that some areas of practice leadership such as infection control were

Are services well-led?

Inadequate

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

unclear. On 27 April 2017 we found that the leadership for infection control was shared between the GP and the practice manager and that action had been taken to make improvements following the previous inspection.

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

- On 15 November 2016 we found that the practice had not always proactively sought patients' feedback and had not engaged patients in the delivery of the service. The practice did not have an active patient participation group (PPG) in place. On 27 April 2017 we viewed minutes of a PPG meeting dated 23 February 2017 and we saw that another meeting was scheduled in May 2017. We also viewed minutes of a staff meeting dated 18 April 2017 where there was a discussion around setting up a questionnaire for patients to suggest improvements within the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not do all that was reasonably practicable to ensure that systems and processes to assess and monitor the service were effective as policies and procedures were not adequately reviewed and kept up to date. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to ensure that risks were appropriately assessed and mitigated. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.