Dr SKS Swedan & Partner

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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection of Dr SKS Swedan & Partner on 10 May 2016 and rated the practice as inadequate for safe and well-led services, requires improvement for effective, caring and responsive and an overall rating of inadequate. The provider was placed into special measures. A follow-up announced comprehensive inspection was undertaken on 23 January 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 10 May 2016. At that inspection we found that insufficient improvements had been made and the provider remained rated as inadequate for safe and well-led services. In line with our enforcement procedures we issued a warning notice in relation to regulation 17: Good Governance of the Health and Social Care Act 2008.

We carried out an announced focused inspection of Dr SKS Swedan & Partner on 15 September 2017. This was to follow-up on a warning notice the Care Quality Commission served following the announced comprehensive inspection on 23 January 2017. The warning notice, issued on 7 March 2017, was served in relation to regulation 17: Good Governance of the Health and Social Care Act 2008. The timescale given to meet the requirements of the warning notice was 12 May 2017.

The inspection on 23 January 2017 highlighted several areas where the provider had not met the standards of regulation 17: Good Governance. We found:

- The provider was failing to assess, monitor and mitigate the risks to patients arising from cervical screening tests being carried out but test results not being received.
- The provider was failing to ensure effective systems for staff employment checks.
- The provider was failing to operate effective systems to assess, monitor and mitigate Infection Prevention and Control (IPC) risks.
- The Practice Manager was off duty for an indeterminate period and there were no systems in place for ensuring emails sent directly to the Practice Manager were being redirected and dealt with by someone else in the practice.
- The provider was failing to operate effective systems to assess, monitor and mitigate fire safety risks.
- The provider was failing to operate effective systems to monitor and improve the quality of services such as customer care.

At this inspection on 15 September 2017 we found that actions had been taken to improve the provision of well-led services in relation to the warning notice. Specifically:

Summary of findings

- The practice had reviewed and revised its systems and processes to ensure a fail-safe system for managing cervical screening.
- The practice had reviewed its recruitment policy and systems to ensure appropriate employment checks were carried out.
- The practice had addressed the recommendations of the Infection Prevention and Control (IPC) audit identified at the previous inspection.
- The practice had engaged an interim practice manager three days per week and were in the process of recruiting for a substantive post.
- The practice had reviewed its systems to assess, monitor and mitigate fire safety risks.
- The practice had delivered customer service training for its reception staff and engaged with the Patient Participation Group (PPG).

Our inspection on 15 September 2017 focussed on the concerns giving rise to a warning notice being issued on 7 March 2017. We found that the provider had taken action to address the breaches of regulation set out in the warning notice. However, the current rating will remain until the provider receives a further comprehensive inspection to assess the improvements achieved against all breaches of regulation identified at the previous inspection.

The comprehensive report of the 23 January 2017 inspection which was published on 11 May 2017 should be read in conjunction with this report.

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 well-led?

During our inspection on 15 September 2017 we found the provider had made improvements to the provision of well-led services in relation to the warning notice. Specifically:

- The practice had reviewed and revised its systems and processes to ensure a fail-safe system for managing cervical screening.
- The practice had reviewed its recruitment policy and systems to ensure appropriate employment checks were carried out.
- The practice had addressed the recommendations of the Infection Prevention and Control (IPC) audit identified at the previous inspection.
- The practice had engaged an interim practice manager three days per week and were in the process of recruiting for a substantive post.
- The practice had reviewed its systems to assess, monitor and mitigate fire safety risks.
- The practice had delivered customer service training for its reception staff and engaged with the Patient Participation Group (PPG).

Dr SKS Swedan & Partner

Detailed findings

Our inspection team

Our inspection team was led by:

This warning notice follow-up inspection was undertaken by a CQC inspector.

Background to Dr SKS Swedan & Partner

Dr SKS Swedan & Partner is situated within the Newham Clinical Commissioning Group (CCG). The practice provides services under a General Medical Services (GMS) contract to approximately 3,000 patients. The practice provides a full range of enhanced services including, child and travel vaccines and minor surgery. It is registered with the Care Quality Commission 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.

The staff team at the practice includes two part-time female GP partners providing between seven and nine sessions per week, one male locum GP one session per week, a part-time locum female practice nurse working 12 hours over three session per week, an interim practice manager three days per week, an assistant practice manager and administrative staff all working a mixture of part-time hours.

The practice's opening hours are 8.30am to 6pm every weekday except Thursday when it opens from 8.30am to 1pm. GP appointments are available Monday and Wednesday from 8.30am to 12noon and 4pm to 6pm, Tuesday and Friday from 9am to 12.30pm and 4pm to 6pm and Thursday from 9am to 12.30pm. Appointments include home visits, telephone consultations and online pre-bookable appointments. Urgent appointments are available for patients who need them. Extended hours are available through the Newham GP Co-operative service every weekday from 6.30pm to 9pm and on Saturday from 9am to 1pm. Patients telephoning when the practice is closed are transferred automatically to the local out-of-hours service provider.

The Information published by Public Health England rates the level of deprivation within the practice population group as three on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice provided data showing its patients demographic is approximately 80% of black and ethnic minority origin.

Why we carried out this inspection

We undertook an announced focused inspection of Dr SKS Swedan & Partner on 10 May 2016 and rated the practice as inadequate for safe and well-led services, requires improvement for effective, caring and responsive and an overall rating of inadequate. The provider was placed into special measures. A follow-up announced comprehensive inspection was undertaken on 23 January 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 10 May 2016. At that inspection we found that insufficient improvements had been made and the provider remained rated as inadequate for safe and well-led services. In line with our enforcement procedures we issued a warning notice in relation to regulation 17: Good Governance of the Health and Social Care Act 2008.

We undertook an announced focused inspection of Dr SKS Swedan & Partner on 15 September 2017. The inspection

Detailed findings

was carried out to review in detail the actions taken by the provider in relation to the warning notice issued by the Care Quality Commission on 7 March 2017 and to confirm that the provider was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with the two GP partners, the interim practice manager, the assistant practice manager, reception and administrative staff. We also spoke with the practice nurse by telephone after the inspection as she was on annual leave at the time of our inspection.
- Spoke with a member of the Patient Participation Group.
- Inspected the facilities, equipment and premises and spoke with the facilities management team responsible for the maintenance and safety oversight of the premises.
- Reviewed systems and process in relation to recruitment, infection prevention and control

Are services well-led?

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

Our findings

At our previous inspection on 23 January 2017, we issued a warning notice for good governance as the arrangements in respect of being a well-led service were in breach of regulation.

Specifically we found:

- The provider was failing to assess, monitor and mitigate the risks to patients arising from cervical screening tests being carried out but test results not being received. At the inspection we asked staff to run a search of patients cervical cytology test results and it showed 33 patients results within the last two years had not been received by the practice, nor had cervical screening tests been repeated for these patients. We asked staff to check for an "inadequate" test result and a patient record from 2015 showed no evidence they had been recalled for a re-test.
- The provider was failing to ensure effective systems for staff employment checks. The provider was not aware a member of the clinical team had a "Caution Order" on their file from their professional registering body and there was no evidence this staff member had medical indemnity insurance or system to ensure this was checked.
- The provider was failing to operate effective systems to assess, monitor and mitigate Infection Prevention and Control (IPC) risks. Required actions from IPC audits had not consistently been identified or undertaken. An IPC audit undertaken in 2015 indicated paper couch rolls should be wall mounted with a completion timescale of 4 weeks but by the day of our inspection this had not been completed.
- An IPC audit dated December 2016 had no action plan and actions identified such as to add infection control for discussion on the staff meeting agenda and to obtain local infection control professionals contact details had not been undertaken.
- The December 2016 audit also contained incorrect information regarding use of chemicals for safe cleaning of the ear irrigator. We looked at the clinical equipment cleaning chart for the ear irrigator which had recorded the last cleaning date as 25 November 2016. Therefore, we could not tell whether the ear irrigator was last cleaned on 25 November or if the cleaning had been carried out but not properly recorded.
- Records showed staff had received up to date infection control training. We asked two staff about how to clean a spillage of bodily fluids to assess their competence on this issue. We expected staff tell us they would use the "spillage kit" kept at the practice. One staff member told us they would clean a spillage of bodily fluids with paper towels and gloves and the other said they would clean it with liquid that kills bacteria. We asked both staff if there was a spillage kit at the practice and both said there was.
- The Practice Manager was off duty for an indeterminate period and there were no systems in place for ensuring emails sent directly to the Practice Manager were being redirected and dealt with by someone else in the practice.
- The provider was failing to operate effective systems to assess, monitor and mitigate fire safety risks. There was no formal evacuation procedure or alternative nominated fire safety lead to cover in the absence of the designated lead.
- The practice had a fire risk assessment dated May 2016 which recommended a fire drill be undertaken in November 2016 but this had not occurred and the designated fire safety lead was not aware of the risk assessment November 2016 recommended date for the next fire drill.
- The last fire extinguisher annual safety checks were undertaken in May 2015 and were overdue.
- The provider was failing to operate effective systems to monitor and improve the quality of services such as customer care. Staff and Patient Participation Group members told us staff had not been managed effectively including in relation to lateness and attitude at work which had a negative impact on patients care.

At our inspection on 15 September 2017 we reviewed the requirements of the warning notice and found the provider had made improvements to the provision of well-led services in relation to the warning notice. Specifically:

- The provider demonstrated it had carried out a reconciliation of all its patients who had undertaken a cervical screening test in the last two years against the national patient data base to ensure its clinical system was appropriately coded and patients who required a follow-up had been recalled. We saw that the practice nurse kept a written log of all cervical screening undertaken and the date the result was received which provided an audit trail for every sample sent and

Are services well-led?

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enabled timely follow-up of any "inadequate" test results. An inadequate test result means the test must be done again because the laboratory was not able to see the cells properly to give a result. We spoke with the practice nurse after the inspection who confirmed this process. The practice manager had trained and was overseeing a member of the administrative team to manage cervical screening recall.

- The provider had reviewed its recruitment policy and systems to ensure appropriate employment checks were carried out. We reviewed two personnel files, which included a staff member who had been recruited since our last inspection on 23 January 2017, and found appropriate recruitment checks had been undertaken prior to employment. For example, interview notes, contract of employment, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. The provider told us the "Caution Order" on a member of its clinical team we had referenced at our previous inspection had expired and we were able to verify this on the professional registering body website. We saw evidence of appropriate medical indemnity insurance covering the role of the clinical staff member.
- We saw evidence that a formal external Infection Prevention and Control (IPC) audit had been undertaken by the Commissioning Support Unit on 6 April 2017. The practice compliance score on IPC standards was 97%. However, it identified some unresolved issues identified at a previous formal audit and the CQC inspection. On the day of the inspection the interim practice manager was unaware that this audit had been undertaken in April and shared with us the findings of an internal audit undertaken in August 2017 to address the findings of our previous inspection. We observed that all recommendations had been actioned. Specifically:

1. Paper couch rolls in all consulting rooms were now wall-mounted.
2. Infection control had been added as a stand-alone agenda item at clinical meetings and we saw evidence of minutes of meetings from July, August and September 2017 where this had been discussed.
3. Appropriate disinfectant tablets were available and used for the cleaning of the ear irrigator as per the manufacturer's instructions. We saw that a written log was maintained to confirm when this had been cleaned.
4. We observed that a spillage kit was available in the nurse's room and was in date. Staff we spoke with were aware of the location of the spillage kit and were able to tell us how to use this for the cleaning of bodily fluids. They told us that personal protective equipment, for example, gloves, were available.

- The practice had engaged an interim practice manager from June 2017 who worked three days a week. We were told that the interim manager would remain in post until a permanent practice manager could be recruited. We saw that the recruitment process was on-going at the time of our inspection.
- The practice had reviewed it fire safety policy and trained all its reception staff as fire marshals. We saw evidence of a rota for fire marshal responsibilities based on the weekly staff rota to ensure a trained member of staff was always available. staff we spoke with were aware of their responsibilities. Staff told us the practice had undertaken a fire evacuation drill in July 2017.
- The practice had liaised with the facilities management team for the health centre to organise a coordinated approach for fire evacuation with the other GP practices within the premises.
- We saw evidence that the fire extinguishers had been checked on 19 July 2017.
- The practice had arranged and delivered some customer service training in August 2017 for its reception staff. The practice manager told us customer care was an ongoing objective of the practice.
- We met with a member of the Patient Participation Group (PPG) who told us that the practice appeared more committed to facilitating regular PPG meetings. It was proposed that these would be held on a quarterly basis and at least one GP Partner and Practice Manager would be in attendance. The group had now nominated a PPG Chair and had held a meeting in July 2017.