The Westway Surgery

Inspection report

13 Westway
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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 location	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

Overall summary

We carried out an announced comprehensive inspection at Westway Surgery on 8 January 2019. The practice was previously inspected in October 2014 and was rated good overall, with requires improvement for the patient population groups of families, children and young people and people who are experiencing poor mental health (including people with dementia).

We based our judgement of the quality of care at this service on a combination of:

•what we found when we inspected

•information from our ongoing monitoring of data about services and

•information from the provider, patients, the public and other organisations.

We have rated this practice as inadequate overall.

We rated the practice as **inadequate** for providing safe services because:

•The practice did not have clear systems and processes to keep patients safe.

•Receptionists had not been given guidance on identifying red flag signs for deteriorating or acutely unwell patients. They were not aware of actions to take in respect of such patients.

•The practice did not have appropriate systems in place for the safe management of medicines.

•The practice did not learn and make improvements when things went wrong.

We rated the practice as **inadequate** for providing effective services because:

•There was limited monitoring of the outcomes of care and treatment.

•The practice was unable to show that staff had the skills, knowledge and experience to carry out their roles.

•The practice was unable to show that it always obtained consent to care and treatment.

•Some performance data was significantly below local and national averages.

We rated the practice as **inadequate** for providing well-led services because:

•The practice was unable to demonstrate effective systems and processes to keep people safe.

•There are inadequate systems and processes in place to be assured of the quality and safety of the service being provided.

•Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.

•The practice did not have a clear or credible strategy.

•The practice culture did not effectively support high quality sustainable care.

•The practice did not have clear and effective processes for managing risks, issues and performance.

•The practice did not always act on appropriate and accurate information.

•We saw no evidence of systems and processes for learning, continuous improvement and innovation.

These areas affected all population groups so we rated all population groups as **inadequate**.

We rated the practice as **requires improvement** for providing caring and responsive services because:

•The practice had limited systems in place to identify carers and provide relevant support.

•Staff dealt with patients with kindness and respect.

•Patients made positive comments about the care and treatment they received.

•Patients could generally access care and treatment in a timely way, although appointment times were limited.

The areas where the provider must make improvements are:

•Ensure that care and treatment is provided in a safe way.

•Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the

Overall summary

process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC inspection manager, GP specialist adviser, and a practice manager specialist adviser.

Background to The Westway Surgery

Westway Surgery is located at 13 Westway, Shepherds Bush, London, W12 0PT. The surgery has good transport links and there is a pharmacy located nearby. The practice is based in an adapted residential building.

The full comprehensive reports of the previous inspections can be found by selecting the 'all reports' link for The Westway Surgery on our website at www.cqc.org.uk

The practice provides NHS primary care services to approximately 3446 patients and operates under a General Medical Services (GMS) contract. The practice is part of NHS North West London Clinical Commissioning Group (CCG).

The practice is registered with CQC as an individual provider, and the regulated activities provided are diagnostic and screening procedures, treatment of disease, disorder or injury and maternity and midwifery services

The practice staff comprises a lead GP who is salaried, a GP partner and one long-term female GP locum (1.25 whole time equivalent (WTE) combined). The medical team are supported by a practice nurse (0.33 WTE). There is a practice manager who is a partner, an assistant practice manager, and four administration/reception staff.

The practice population is in the second most deprived decile in England. There are higher than average numbers of patients in the 25 to 44 age range, with the number of people over the age of 75 lower than the national average. Male life expectancy is 78 years compared to the national average of 79 years. Female life expectancy is 84 years compared to the national average of 83 years.

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 represents the highest levels of deprivation and level ten the lowest.

The practice reception is open Monday to Friday between 9.30am-6.30pm with the exception of Wednesday when the practice closes at 1.30pm. Consultation times are between 10.00am-1.30pm and 3.30-6pm each day except for Wednesday. When the practice is closed patients are directed to contact the local out of hours service and NHS 111. Patients may book appointments by telephone, online or in person. Out of hours services are provided by London Central and West.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Warning Notices** A Warning Notice was issued. **How the regulation was not being met:** • The provider failed to recognise a safeguarding concern and did not report this to the appropriate authorities. • The provider did not have a system to safety net and protect children for whom there are safeguarding concerns, to ensure they are reviewed. • The provider did not attend meetings with health visitors, which would have provided a system to safety net and protect children. • The provider did not provide evidence they have a risk register for vulnerable people. • The provider was unsure whether safeguarding information was shared with out of hours services. • The provider had failed to ensure that staff had undertaken effective chaperone training. • The provider did not demonstrate they had a child fail-safe system was in place for young girls and women for whom there were safeguarding concerns regarding female genital mutilation (FGM), to ensure they are reviewed. • The provider did not ensure they had an effective system in place regarding recruitment. • The provider did not provide evidence that all staff in direct clinical contact had undertaken the requisite blood tests and vaccinations to keep patients safe, in line with current Public Health England (PHE) guidance.

This section is primarily information for the provider

Enforcement actions

- The provider had overstocked the fridge, vaccines were touching the back, top and sides which may prevent the air cooling system, which keeps vaccines at an optimum temperature, to ensure they are safe and effective. There were two thermometers in situ, both of which read at different temperatures and staff were unable to confirm which temperature was consistently recorded.
- The provider had not conducted appropriate risk assessments and did not provide evidence they have systems in place to safely manage premises, equipment and environment for patients and staff. This relates to infection prevention and control; legionella; health and safety; premises and security; control of substances hazardous to health (COSHH) and locum GPs own medical equipment.
- Practice premises were found to be dirty in all areas, we found dirt and dust across all surfaces including patient treatment couches, equipment and clinical surfaces. The provider did not keep cleaning records and did not audit cleaning standards.
- The provider did not have an effective system in place for the monitoring of uncollected prescriptions including for patients whose mental health made them vulnerable.
- The provider did not have an automated external defibrillator (AED) preferably with facilities for paediatric use as well as use in adults. They did not have an appropriate risk assessment in place for not having an AED. The plan regarding this was to access the defibrillator at a neighbouring practice which is ten minutes walking distance away.
  The emergency kit should include medicines to deal with a range of commonly occurring emergencies. The medicines included are hydrocortisone for injection to treat an allergic reaction, dexamethasone 5mg/2.5ml oral solution to treat croup and furosemide used to treat heart failure. The risks of not having these medicines available to staff and how staff should respond in the event they needed them had not been considered.
- The provider did not have a system in place to check other medicines and clinical supplies. There was

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Enforcement actions

evidence found regarding an ampoule of an injectable drug in a clinical room, which had passed its expiry date and a box of urine testing strips that had passed its use-by date which may render any resulting data unreliable.

- The provider did not have an effective system to safely manage patients that were administered high-risk medicines.
- The provider did not ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. They had not assured themselves of the competency of the practice nurse.
- The provider had not ensured that all non-clinical staff were trained in identifying deteriorating or acutely unwell patient's suffering from potential illnesses such a sepsis.
- The provider did not have a system or policy in place which ensured that all children who did not attend their appointment following referral to secondary care or for immunisations were appropriately monitored and followed up.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Warning Notices** A Warning Notice was issued. How the regulation was not being met: There was a lack of systems and processes established and operated effectively to ensure compliance with requirements to demonstrate good governance. In particular we found:

This section is primarily information for the provider

Enforcement actions

- The provider had failed to ensure sufficient clinical capacity for GP's and the practice nurse to enable them to meet patients' needs safely.
- The provider did not have a system and policy to safely manage test results and that cover for annual leave/buddying arrangements was in place regarding the safety netting and management of test results.
- The provider failed to have a system or policy in place to safety net 2WW referrals.
- The provider failed to have a system or policy in place to safety net medicines safety alerts, patient safety alerts, recalls and rapid response reports.
- The provider did not have a system or process in place to safely manage requests for repeat prescriptions.
- There was evidence the prescription box was not checked regularly, and prescriptions found dated back to October 2018. The provider did not have a system or policy in place to effectively manage repeat prescription requests.
- There were no arrangements in place regarding the healthcare assistant, (HCA) to satisfy the requirement for an overarching policy regarding the HCA scope and role. The provider did not have a protocol in place regarding each task/procedure that was performed and in addition, there was no evidence of appropriate clinical oversight for the HCA.
- The provider did not recognise or record all significant events and this impacted on staff being able to develop effective learning from significant events and incidents.
- The provider did not have a system or policy in place to monitor professional registration status of clinical staff on an ongoing basis.
- Training had not been completed for all staff, including basic life support, infection prevention and control and dementia awareness.

This section is primarily information for the provider

Enforcement actions

- The provider did not have effective embedded systematic risk assessment processes to improve quality outcomes for patients, for cervical cancer screening, long term conditions and childhood immunisations.
- Practice policies were not being reviewed and updated annually.
- There was limited evidence of appropriate discussion, learning and sharing from clinical meetings conducted.
- There was no evidence the provider had reviewed the needs of patients and ensured the services offered met their specific needs and they did not have a hearing loop in place for those patients who are hard of hearing.
- The provider did not seek feedback from patients to drive improvements and address any concerns.

This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.