Dr Yousef Rashid

Quality Report

Orchards Health and Family Centre
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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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Yousef Rashid also known as Shifa Medical Practice on 5 December 2016 and rated the practice as requires improvement for safe, effective and well-led key questions. This led to an overall rating of requires improvement. Breaches of legal requirements were found and requirement notices were issued in relation to patient safety and governance. The full comprehensive report can be found by selecting the http://www.cqc.org.uk/provider/1-199797857 link for Shifa Medical Practice on our website at www.cqc.org.uk.

This inspection was an announced focused inspection which we undertook on 6 November 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 5 December 2016. This report covers our findings in relation to those requirements. The overall rating from this visit remains requires improvement. Our key findings across all the areas we inspected were as follows:

- The practice had few policies to govern activities and those we reviewed were not fit for purpose as they were outdated and/or contained incorrect information.
- Verbal complaints were not formally recorded and we did not see evidence they were discussed during staff meetings.
- Staff who acted as chaperones were not trained for the role and had not received a Disclosure and Barring Service (DBS) check.
- We found the practice was still failing to carry out appropriate recruitment checks prior to employment.
- This practice's performance was below local and national averages for management of diabetes.
- At the inspection of 5 December 2016, the practice had identified two patients as carers. At this inspection, 11 patients were identified as carers which was less than one percent (1%) of the practice list.

Importantly, the provider must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider should make improvements are:

- Update business continuity plan to include contact details for all members of staff so that they can be contacted should an emergency arise.
- Take steps to improve the practice's performance in the management of diabetes.

Summary of findings

- Review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Dr Yousef Rashid

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.

Background to Dr Yousef Rashid

Dr Yousef Rashid also known as Shifa Medical Practice is located in Barking, Essex and provides primary medical services to approximately 2300 patients. Services are provided under a Personal Medical Services (PMS) contract with NHS England and the practice is part of the Barking and Dagenham Clinical Commissioning Group (CCG). (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services).

Shifa Medical Practice is registered as an individual with the Care Quality Commission (CQC) to provide the regulated activities of treatment of disease, disorder or injury, maternity and midwifery services, surgical procedures and diagnostic and screening procedures from Gascoigne Road, Barking, Barking and Dagenham, IG11 7RS.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to 10. Thirty three percent of patients on the list were aged 18 or younger compared with the national average of 21%. The number of people over the age of 65 was 4% compared to the national average of 17%. The practice provided services to a large housing estate, located close to the surgery. There was a high number of single parent families and many families were on low incomes. Twelve percent of the population were unemployed compared with 5% nationally.

There is one full time GP who provides nine sessions per week and a practice nurse who works one to two sessions a week. The GP was supported by four reception staff.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are offered on Monday between 6.30pm and 8pm. Urgent appointments as well as telephone consultations are also available daily. Out of hours services are delivered by another provider which is detailed in the practice leaflet, posters at reception, website and can be directly accessed by calling the practice telephone number.

The practice was inspected under the Care Quality Commission's current inspection regime in December 2016 and was found to be in breach of Regulation 12 HSCA (RA) Regulations Safe care and treatment and Regulation 17 HSCA (RA) Regulations 2014 Good Governance. This led to an overall rating of requires improvement.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 5 December 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of chaperoning, DBS checking, medicines management relating to Patient Group Directions (PGDs) and recruitment checks were needed improvement to ensure patient and staff safety. A Requirement Notice was issued in relation to these breaches.

Most of these arrangements had not improved when we undertook a follow up inspection on 6 November 2017; the practice still had not ensured staff who acted as chaperones were formally trained for the role and they had not received a Disclosing and Barring check (DBS) and the practice had not undertaken a risk assessment to determine why one was not necessary. The practice remains rated as requires improvement for providing safe services.

Safety systems and processes

- At our previous inspection on 5 December 2016 we found that non-clinical staff who acted as chaperones had not received formal training and risk assessments for Disclosure and Barring Service (DBS) checks were not 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). At this inspection we found staff had not received formal training or received DBS checks. The practice told us the non-clinical staff were all new recruits, however we found there were members of staff who had been employed for over two years.
- At the inspection of 5 December 2016 we noted that the systems for safely managing healthcare waste was not always adhered to, for example, we found sharp bins in the treatment rooms were not signed and dated in accordance with best practice. When we undertook our follow up inspection on 6 November 2017 we found this issue had been resolved satisfactorily.
- At our inspection of 5 December 2016 blank prescription forms were kept in a filing cabinet which was kept unlocked during the day and there was no process for recording when they were used. At this inspection we found these processes had improved, for example, the practice told us they logged the serial numbers for each used prescription. Blank prescriptions were stored in a filing cabinet which could only be accessed by employees. We were told that the filing cabinet as well as the entrance door to the storage door was closed at the end of each day.
- At the inspection of 5 December 2016 the practice could not demonstrate they had adopted Patient Group Directions (PGDs) to allow nurses to administer medicines in line with legislation.
- At our inspection of 5 December 2016 we reviewed four staff files and found appropriate recruitment checks had not been undertaken prior to employment.

Risks to patients

- At our inspection of 5 December 2016 we found that there were procedures in place for monitoring and managing risks to patient health and safety, however we found the health and safety policy was last updated in 2009 which meant it was not fit for purpose. At our inspection on 6 November 2017 we saw that the practice had an up to date policy, however the policy stated that “the practice manager (PM) will ensure that employees under their control are provided with appropriate health & safety training.” We noted that the practice did not have a practice manager in place at the time of our inspection.
- Service was provided solely by the GP Principal who undertook nine weekly sessions. We reviewed the appointment lists and found the practice had not used any locum GPs for over two years. We noted that a name plaque in the reception area informed patients that there were two GPs available, however this was incorrect. We brought this to the GP’s attention who told us this would be removed.
- At our previous inspection of 5 December 2016 the practice did not have a business continuity plan for major incidents such as power failure. Instead the practice told us this would be organised by the building manager. At this inspection the practice had a business continuity plan in place, however the plan did not include emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 5 December 2016, we rated the practice as requires improvement for providing effective services as improvements were needed to the management of some long term conditions such as diabetes.

These arrangements showed little improvement when we undertook a follow up inspection on 6 November 2017. The practice remains rated as requires improvement for providing effective services.

Monitoring care and treatment

The most recent published Quality Outcome Framework (QOF) results were 75% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 96%. The overall exception reporting rate was 0.4%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).)

At the previous inspection of 5 December 2016, the most data available at the time showed the practice's performance for diabetes was below local and national averages. At this inspection on 6 November 2017 published data from April 2016 to March 2017 showed at 30% combined performance for diabetes related indicators were considerably below the CCG average of 84% and national average of 91%. The practice's exception reporting for diabetes monitoring was below 1% for all indicators; this was better than the CCG and national excepting reporting rates. The practice's was aware of this and told us they had put steps in place to improve this. For example, the practice participated in national diabetes audits and used this information to improve patient's outcomes by identifying those at risk of developing diabetes and taking steps to prevent this through behavioural change strategies such as diet. The practice also told us annual review letters were sent to patients and appointment times were extended for these patients. Patients who found it difficult to adhere to treatment were referred to local diabetes educational programmes.

Effective staffing

At the previous inspection of 5 December 2016 we found not all staff had received an annual appraisal. At this inspection on 6 November this issue had not been resolved. We found appraisals last took place in September 2016 and we did not see evidence of any other on-going support.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 5 December 2016, we rated the practice as requires improvement for providing well-led services as there were gaps in the governance arrangements.

We issued a requirement notice in respect of these issues and found arrangements had not improved when we undertook a follow up inspection of the service on 6 November 2017. The practice remains rated as requires improvement for being well-led.

Vision and strategy

At our previous inspection on 5 December 2016 the GP told us the practice was in a period of transition with key staff leaving. At this inspection of 6 November 2017 the GP told us three members of non-clinical staff had resigned since our last inspection. We also found that the practice had not used locum GPs for over two years.

Governance arrangements

At the inspection of 5 December 2016 we found the practice did not have a clear governance framework or structure which clarified the roles and responsibilities of all staff. At this inspection on 6 November 2017 there was little evidence to suggest improvements had been made to the governance arrangements.

The staffing structure remains unclear. The GP referred to reception/administrative staff as the practice manager, however staff told us they were still considering taking on the practice manager's role at the time of our inspection. At the inspection of 6 November 2017, practice policies we reviewed were not fit for purpose; they were incomplete, outdated and contained incorrect information. For example, the complaints policy made reference to the Primary care Trust (PCT), however this organisation was abolished in March 2013. In addition, the policy stated that complaints should be addressed to a member of staff who was no longer employed at the practice.

At our inspection of 5 December 2016 we found verbal complaints were not recorded. At this inspection the practice told us they had received three verbal complaints, however they were not formally recorded and we did not receive minutes of meeting where these were discussed.

Managing risks, issues and performance

At our previous inspection the practice did not provide us with a business plan. At the inspection of 6 November 2017 inspection we saw evidence of a business continuity plan, however the plan referred to a reception/administrative staff as the "practice manager." The practice did not have a practice manager in post at the time of inspection.

At our previous inspection we found non-clinical staff who acted as chaperones had not received formal training to carry out this role and the practice had not requested Disclosing and Barring Service check (DBS). The provider could not provide evidence staff were risk assessed. At this inspection we found these issues remain unaddressed; the GP told us staff who had received chaperoning training had since left the practice. The two newest non-clinical staff were recruited in June and July 2017. The provider was still failing to maintain complete and detailed records relating to the employment of staff.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not do all that was reasonably practicable to provide safe care and treatment. In particular: • Staff who acted as chaperones were not trained for the role and the practice failed to risk assess staff needing a Disclosure and Barring Service (DBS) check. • The practice failed to undertake appropriate pre-employment and recruitment check. 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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were governance systems and processes in place however these were not always effective and compliant with the requirements of the fundamental standards of care. In particular: • Practice policies were not fit for purpose as they were outdated and contained incorrect information. • There were no systems or processes in place to support the breaches identified in Regulation 12.

This section is primarily information for the provider

Requirement notices

- There were no systems in place to identify the learning needs of staff; we did not see evidence of any staff having received an appraisal within the last 12 months.

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.