Dr Jamil Khan

Inspection report

66 Brighton Road
Coulsdon
Surrey
CR5 2BB
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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	Requires improvement
Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

This practice is not rated in this inspection. (Previous rating April 2018 – Inadequate)

The key questions are rated as:

Are services safe? – not rated.

Are services effective? – not rated

Are services well-led? – not rated

We carried out an unannounced focused inspection at Dr Jamil Khan on 14 June 2018 to follow up on breaches of regulations on safe, effective and well-led key questions. The practice remains rated overall as inadequate.

At this inspection we found:

- The practice had put some systems in place to monitor patients on high risk medicines; however, we found that the systems in place were inconsistent.
- The practice had put a system in place to monitor the temperature of medicines refrigerators daily; however, we found a number of instances since the last inspection in February 2018 where the refrigerator temperatures had not been monitored.
- The practice had put a clear system in place to monitor uncollected prescriptions and to follow-up on patients who do not attend their appointments to review their non-urgent abnormal test results.
- Unverified data from the Quality and Outcomes framework for 2017/18 indicated that patient outcomes were significantly below when compared to the 2016/17 results.
- The practice did not have a clinical audit program and had not undertaken any recent clinical audits.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way for service users including a clear, embedded system in place to monitor patients on high risk medicines.
- Ensure that all patients' needs are identified and care and treatment meet their needs including improving outcomes for patients with long-term conditions.

The provider has been rated as inadequate in June 2016, requires improvement in June 2017 and as inadequate again on February 2018. We found this had not been improved at this inspection. We are therefore taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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)	

Our inspection team

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

Background to Dr Jamil Khan

Dr Jamil Khan / The Coulsdon Medical Practice provides primary medical services in 66 Brighton Road, Croydon CR5 2BB to approximately 3,700 patients and is one of 52 practices in Croydon Clinical Commissioning Group (CCG). The practice has no website.

The clinical team at the surgery is made up of one full-time male lead GP, one part-time long-term female locum GP and two part-time female practice nurses. The non-clinical practice team consists of two practice managers and four administrative or reception staff members.

The practice population is in the third least deprived decile in England. The practice population of children and working age people are below the CCG and national averages and the practice population of older people is above the CCG and national averages.

The provider is registered as an individual with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease, disorder or injury.

Are services safe?

We did not rate this key question during this inspection.

Information to deliver safe care and treatment

Staff did not have always have the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was not always available to staff in respect to monitoring patients on high risk medicines.
- We were not assured the practice were able to accurately identify patients who were prescribed high risk medicines; we found the list of patients with high risk medicines provided by the practice to be incomplete which indicated that these patients may not have been appropriately coded.

Appropriate and safe use of medicines

The practice did not have effective systems for appropriate and safe handling of medicines.

- Following the last inspection on February 2018 the practice put some systems in place to monitor patients on high risk medicines; however, we found that the systems in place were not adequate. For example, there were three different systems to monitor patients taking warfarin (medicine that increases the time that blood takes to clot) including scanning of details from the yellow book into the patient records, a software system that showed blood test results from hospitals and a local software system which flagged overdue blood tests and potential medicine interactions. Our review of patient records identified concerns with the effectiveness of all three systems. For example, the system of scanning the yellow book into the patient records was inconsistent and was not routinely undertaken
- During the inspection we reviewed the records of 15 patients taking warfarin, of which there were issues with the monitoring for nine patients. The practice did not recognise the risk this posed to patients' health, for example patients can develop warfarin induced skin necrosis if an incorrect dosage of warfarin (medicine used to stop blood clotting) was taken by patients. The following were the issues we found:
- Six patients were prescribed warfarin without the signing doctor having sight of their most recent blood test result.
- One patient had their prescriptions issued at short intervals without a reason recorded in the patient notes. No information was recorded on the patient's record to indicate any variation in their blood test results, action taken in response to this, and the dosage given to the patient.
- One patient's dosage of warfarin was not reviewed and changed despite variation in their blood test results.
- Two patients' warfarin blood test recording book (also known as yellow book) were not appropriately scanned in their patient management system to record their most recent blood results according to their policy so the prescribing doctor would not be aware of the results and could not be sure if it was safe to continue prescribing.
- It was not clear whether one patient was still prescribed warfarin from the patient notes.
- We were not assured the practice were able to identify patients who were prescribed high risk medicines as during the inspection we requested from the practice a list of patients being prescribed warfarin and our review of the patient management system found this list to be incomplete. This meant the provider could not be sure all patients on this medicine were appropriately prescribed and monitored.
- During the inspection we reviewed the records of three patients taking lithium (medicine used to treat mental health conditions). We found that patient one patient was not collecting their prescriptions regularly and there was no record to show that the patient has been contacted to review why this was. It is crucial to regularly monitor patients on this medicine as abrupt discontinuation increases the risk of relapse of their mental health condition.
- We reviewed the records of three patients on methotrexate (a medicine used in conditions such as rheumatoid arthritis) and found that one patient was prescribed methotrexate without the signing doctor having sight of their most recent blood test result so they could not be sure it was safe to continue prescribing. It is crucial to regularly monitor patients on this medicine as inadequate monitoring my increase the risk of harm to blood, stomach, liver and lungs.
- During the inspection we reviewed the records of seven patients taking azathioprine (medicine used to treat rheumatoid arthritis) and found that two patients were prescribed azathioprine without the signing doctor having sight of their most recent blood results so the

Are services safe?

prescribing doctor could not be sure it was safe to continue prescribing. Again, we were not assured the practice were able to identify patients who were prescribed azathioprine; we requested from the practice a list of patients on azathioprine and found this list to be incomplete.

- During the inspection we found a number of instances where the temperature of refrigerators that stored medicines had not been monitored. This issue was fed back to the provider during the last inspection on 7 February 2018; however, the provider informed us that they only put a system in place to regularly monitor refrigerator temperatures from April 2018, about eight weeks after the last inspection; despite this we identified three instances during which the refrigerator temperatures were not monitored in April 2018.
- We found that the provider regularly checked uncollected prescriptions. At our previous inspection on 7 February 2018 we identified that the practice did not regularly monitor uncollected prescriptions and this issue was fed back to the provider. At this inspection we found the practice had implemented a new system for the monitoring of uncollected prescriptions, however this new system was only implemented in May 2018.

Lessons learned and improvements made

- The practice had a system in place to manage medicines and safety alerts since August 2016. We looked at the action undertaken for three random examples of medicines and safety alerts and found that they were appropriately acted on; however, the practice had not reviewed any medicines and safety alerts before August 2016.

Please refer to the Evidence Tables for further information.

Are services effective?

We did not rate this key question during this inspection .

Effective needs assessment, care and treatment

We saw that the GP did not always assess patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The system to monitor patients on high risk medicines was not effective.

Monitoring care and treatment

The practice had not undertaken any clinical audits since the inspection on 7 June 2017.

- Unverified Quality and Outcomes Framework (QOF) results for 2017-18 provided by the practice indicated that the practice had achieved only 63.3% of the total number of points available; this is significantly lower than the 2016-17 results where the practice achieved 76% which was significantly below the Clinical Commissioning Group (CCG) average of 95.8% and national average of 95.5%.

Coordinating care and treatment

- During this inspection we found that the provider had put a system in place to follow-up patients who did not attend their appointments to review non-urgent test results

Please refer to the evidence tables for further information.

Are services well-led?

We did not rate this key question during this inspection.

Leadership capacity and capability

Leaders did not demonstrate they have the capacity and skills to deliver high-quality, sustainable care.

- Following the inspection in February 2018 the provider had put some systems in place to monitor patients on high risk medicines; however, we found that these were not adequate to ensure safe care for patients.
- The quality and outcomes framework (QOF) outcomes for patients with long term conditions were significantly below average for 2015/16, 2016/17 and 2017/18.
- The provider had not performed any clinical audits since the June 2017 inspection and had no other systems of quality assurance; the provider had not undertaken all the required improvements we identified at our last inspection.

Governance arrangements

The governance arrangements in place did not demonstrate adequate improvements since the last inspection on 7 February 2018 to ensure sustained safe and effective care for patients.

- During this inspection we found repeated breaches of regulations identified in the last inspection. The improvements made by the provider since the last inspection were not consistent.
- Following the last inspection on 7 February 2018 the provider sent us a log of activities they would undertake as part of their action plan which the provider had informed us had been completed; however, we found that some of these activities had not been carried out. For example, the provider said they undertake weekly water temperature checks and monthly flushing of external water outlets; we found these were not undertaken; the provider said they perform a bi-monthly search on patients with learning disability and would invite them for screening; we found this was not undertaken.
- We also found that there had been a significant delay in implementing some of the actions from the previous inspection findings. For example, the system to monitor the refrigerator temperature took eight weeks to develop and put into operation. This indicated a lack of understanding of risk this posed to patients and a failure to prioritise responding to the issues identified during the last inspection in a timely manner to ensure the services provided were safe and effective.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- The provider had not adequately addressed the issues we found during the last inspection on 7 February 2018 in relation to the monitoring of patients on high risk medicines and monitoring of refrigerator temperatures that stored medicines.
- The provider had failed to respond to some of the areas identified in our previous inspections, for example the provider had not completely rectified their clinical coding of patients with long-term conditions.
- The provider had not undertaken any recent quality improvement activity, for example the provider had not undertaken a review of their patient records to ensure treatment was delivered according to evidence based guidance.

Please refer to the evidence tables for further information.