Dr Safderali Lalji Datoo

Quality Report

Watford Way Medical 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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
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 Safderali Lalji Datoo (also known as Watford Way Medical Centre) on 14 June 2017 and an unannounced focussed inspection on 19 June 2017. Overall the practice is rated as inadequate.

This inspection was a follow up to our earlier inspections on 26 August 2015 where the practice was rated inadequate overall and 18 May 2016 where the practice was rated requires improvement overall. At the inspection on 18 May 2016 there were breaches in legal requirements relating to the provision of safe, effective and well led services. Safe was rated as inadequate due to issues with medicines management and issues with processing pathology results. The practice was placed into special measures in November 2015 and remained in special measures after the May 2016 inspection. Following the latter inspection, a warning notice was served on the provider to address the issues with inadequate medicines management.

At our inspection on 14 and 19 June 2017 we found that the provider had not taken sufficient steps to address the issues in the warning notice. Significant improvements were still required in the areas of medicines management, record keeping and following national guidance.

Our key findings across all areas we inspected were as follows:

- We were not assured from both our interviews with GPs and the review of patient records that GPs had read or implemented relevant nationally recognised guidance, particularly in relation to medicines management.
- The system and process in place for prescription management was inadequate. There was a risk that patients would receive medicines that were not appropriate to their current needs due to out of date prescriptions being given to patients.
- Patients were at risk of harm, particularly those taking high risk medicines, because if patients did not collect their prescriptions, there was no follow up by the practice

Summary of findings

- We found examples of poor care for vulnerable patients with a lack of detail in patient notes and no care plans were in place.
- It was difficult to ascertain what improvements had been made to the care of patients following a clinical audit being undertaken.
- Information about services and how to complain was available. However there was confusion with regard to what was documented as a complaint.
- There was a system in place for reporting and recording significant events. However the practice did not undertake any analysis of these to aid further learning.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their treatment.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure though this did not support adequate governance. Staff felt supported by management.

The areas where the provider must make improvements are:

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

In addition the provider should:

- Improve staff understanding of what constitutes a complaint and record accordingly.
- Look at ways to improve QOF figures in relation to the management of patients with diabetes.
- Look at ways to improve on the results of the national GP patient survey.

Following the inspection the practice informed us that some steps have been made to improve systems within the practice, including reviewing policies in line with national guidelines and further training for clinical staff.

On 21 July 2017 because of significant concerns we took urgent enforcement action to suspend Dr Safderali Lalji Datoo as the provider of services from providing general medical services under Section 31 of the Health and Social Care Act 2008 for a period of six months to protect patients.

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

The practice was rated as inadequate for providing a safe service and improvement must be made.

- There was a system for reporting and recording significant events. However we found no evidence that the practice carried out an analysis of recorded significant events.
- Patients were at risk of harm because inadequate systems were in place to keep patients safe including those for prescription and medicines management.
- There was insufficient attention to child safeguarding. Staff did not always recognise or respond appropriately to abuse.

Are services effective?

Inadequate

The practice was rated as inadequate for providing an effective service and improvements must be made.

- People's care and treatment did not always reflect current evidence based guidance, standards and practice. The practice had systems in place to keep clinical staff up to date. However we were not assured that GPs had read or implemented relevant nationally recognised guidance, particularly in relation to medicines management.
- The information needed to plan and deliver effective care to people was not available at the right time. Information about people's care was not always appropriately shared. We found patient notes were not always contemporaneous and there was confusion in some patient notes as to who was responsible for the care and treatment of patients.
- The GP did not understand all the relevant consent and decision-making requirements of legislation and guidance. The lead GP was unaware of the Gillick and Fraser competency framework.
- The practice undertook clinical audits but it was difficult to ascertain what improvements had been made to the care of patients.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice in line with the national average for several aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice was rated as requires improvement for providing a responsive service.

- Information about how to complain was available and easy to understand. However, we could not be assured that all complaints had been satisfactorily handled, recorded, or dealt with in a timely way. Staff showed a lack of awareness as to what constituted a complaint.
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice referred patients with long-term chronic and medically complex conditions to a CCG crisis care team to prevent admission or readmissions to hospitals and to support end of life care pathways.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

The practice was rated as inadequate for providing a well led service and improvements must be made.

- The practice had taken steps to develop an overarching governance framework however there was a need to review processes in relation to medicines management and care planning to ensure it is failsafe.We found examples of poor record keeping which put patients at risk. Since the inspection the lead GP undertook record keeping training in September 2017 in order to improve the quality of records within the practice.

Summary of findings

- There was no established programme of quality improvement for the practice. The practice had a vision to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings though these did not identify shortcomings.
- The practice had a number of policies and procedures to govern activity.
- The practice had systems in place for notifiable safety incidents.
- Since our last inspection, the practice had begun to proactively seek feedback from staff and patients and we saw evidence that this was acted on. The patient participation group was now active.
- There was not a strong focus on continuous learning an improvement at all levels; specifically in terms of the clinical governance systems and processes.

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

Inadequate

The provider was rated as inadequate for being safe, effective and well led, requires improvement for being responsive and good for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Inadequate

The provider was rated as inadequate for being safe, effective and well led, requires improvement for being responsive and good for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There was insufficient assurance to demonstrate people with long term conditions received effective care and treatment which reflected current evidence based practice.
- Performance for diabetes related indicators was comparable to the national average.
- Longer appointments and home visits were available when needed.

Families, children and young people

Inadequate

The provider was rated as inadequate for being safe, effective and well led, requires improvement for being responsive and good for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. However we were not assured that these systems were effective as the practice stated that there were currently no children on the practice child protection watch list.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.

Summary of findings

- The practice's uptake for the cervical screening programme was 79% which was comparable to the national average of 72%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for being safe, effective and well led, requires improvement for being responsive and good for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There was insufficient assurance to demonstrate working age people (including those recently retired and students) received effective care and treatment which reflected current evidence-based practice.
- Patients could book appointments and order repeat prescriptions online.
- Health promotion advice was available in the waiting area.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for being safe, effective and well led, requires improvement for being responsive and good for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There was insufficient assurance to demonstrate people whose circumstances may make them vulnerable received effective care and treatment.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability. However the practice had not completed care plans for those patients that required them.
- The practice informed vulnerable patients about how to access various groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for being safe, effective and well led, requires improvement for being responsive and good for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group

Summary of findings

- There was insufficient assurance to demonstrate people experiencing poor mental health (including people with dementia) received effective care and treatment which reflected current evidence based practice.
- The lead GP showed a lack of awareness of consent procedures, including Gillick and Fraser competency. We were therefore not assured when providing care and treatment that relevant consent was being sought.
- Performance for dementia related indicators were above the national average. One hundred percent of patients diagnosed with dementia had had their care reviewed in the preceding 12 months compared to the national average of 85%.
- Performance for mental health related indicators were above the national average. For example, one hundred percent of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the last 12 months compared with a national average of 91%.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results were published July 2016. The results showed the practice was performing in line with local and national averages. Three hundred and twenty eight survey forms were distributed and 112 were returned. This represented 5% of the practice's patient list.

• 79% of patients found it easy to get through to this practice by phone compared to the CCG average of 66% and the national average of 73%.

• 74% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.

• 79% of patients described the overall experience of this GP practice as good compared to the national average of 85%.

• 63% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 55 comment cards which were all positive about the standard of care received. All comment cards stated that practice staff were very kind, caring and supportive. Two comment cards said they had to wait too long after their appointment time to be seen by the doctor.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were very approachable, committed and caring. Patients told us that staff knew them well and made them feel very comfortable whenever they had contact with the practice. One hundred percent of patients in the friends and family test would recommend this practice (37 responses).

Areas for improvement

Action the service MUST take to improve

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Improve staff understanding of what constitutes a complaint and record accordingly.
- Look at ways to improve QOF figures in relation to the management of patients with diabetes.
- Look at ways to improve on the results of the national GP patient survey.

Dr Safderali Lalji Datoo

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 second CQC inspector and a GP specialist adviser.

Background to Dr Safderali Lalji Datoo

Dr Safderali Lalji Datoo, also known as Watford Way Medical Centre, is located in Hendon in the London Borough of Barnet. It is one of the 62 member GP practices in NHS Barnet CCG. The practice holds a Primary Medical Services contract (an agreement between NHS England and general practices for delivering primary medical services). The practice provides enhanced services for adult and child immunisations and extended hours.

The practice is registered with the Care Quality Commission to carry on the regulated activities of Treatment of disease, disorder or injury; Diagnostic and screening procedures; Maternity and midwifery services.

The practice has approximately 2,150 registered patients at the time of our inspection.

The staff team at the practice included one principal GP (male) working four sessions a week, a female salaried GP working four sessions a week and another female salaried GP working one session a week. One practice nurse (female) working 20 hours a week, a full time practice manager and two full time receptionists one of which was also the trained healthcare assistant.

The practice's reception opening times are:

Monday 9am – 12pm and 4pm – 6pm

Tuesday 9am – 12pm and 5pm – 7pm

Wednesday 9:am – 12pm

Thursday 9am – 12pm and 4pm – 6pm

Friday 9am – 12pm and 4pm – 6pm

The practice's GP consulting times are:

Monday 9am - 11:30am and 4pm – 6pm

Tuesday 9am - 11:30am and 5pm - 7:30pm

Wednesday 9am - 11:00am

Thursday 9am - 11:30am and 4pm – 6pm

Friday 9am - 11:30am and 4pm – 6pm

Nurse appointments were available on a Monday, Tuesday, Thursday and Friday between 9.30am and 12.30pm and between 4pm and 6.30pm on a Thursday. Urgent appointments are available each day and GPs also complete telephone consultations for patients. There is an out of hour's service provided to cover the practice when it is closed. If patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on their circumstances. Information on the out-of-hours service is provided to patients on the practice leaflet as well as through posters and leaflets available at the practice.

The practice serves a predominantly White British population (64%). A further 19% identifies itself as Asian / Asian British and 8% as Black / African /Caribbean / Black British. The practice has a lower than average percentage than the national average of people with a long standing health conditions (42% compared to 49%). At 81 years, male life expectancy is above than the England average of 79 years. At 87 years, female life expectancy is above the England average of 83 years.

Detailed findings

The practice was previously inspected on 26 August 2015 when it was rated inadequate overall and placed in special measures. After a further inspection on 18 May 2016, the practice was rated overall as requires improvement and remained in special measures.

Why we carried out this inspection

We carried out a comprehensive inspection of this service on 14 and 19 June 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated inadequate in August 2015 and was placed into Special Measures in November 2015. Being placed into Special Measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration. Requirement notices set out the action we told the provider to take following the inspection carried out in August 2015. A further inspection was carried out on 18 May 2016 and the practice was rated as requires improvement. The practice remained in special measures and a warning notice was issued in relation to medicines management and the checking and acting on pathology results.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, for example NHS England and the local Clinical Commissioning Group to share what they knew. We carried out an announced visit on 14 June 2017 and an unannounced visit on 19 June 2017. During our visits we:

- Spoke with a range of staff (GPs, practice manager and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- 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).

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

Following our inspection on 26 August 2015 the practice was rated as inadequate for providing safe services. Not all staff had received training in safeguarding adults and children and staff expected to perform chaperone duties had not had a Disclosure and Barring Service (DBS) check 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. The practice had no method for identifying, recording and managing risks associated with health and safety for example; fire safety checks and infection control processes had not been managed in accordance with NHS guidelines. Arrangements for managing medicines were not effective as there were no Patient Group Directions (PGDs) in place. These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The practice was not equipped to deal with medical emergencies.

At our inspection on 18 May 2016 we found some improvements had been made. However, during this inspection we found that safety systems and processes in regard to patient medicines reviews were inadequate.

At our inspection on 14 and 19 June 2017 we found that little action had been taken in regard to the issues identified in the previous inspection. We also found that there were shortfalls with regard to prescription management and the management of patients on high risk medicines such as methotrexate.

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

- We saw evidence in the practice significant event analysis forms that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- However, we found no evidence that the practice carried out an analysis of its recorded significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw one example of lessons were shared and where action was taken to improve safety in the practice. For example, an incident occurred when a prescription was issued to a patient incorrectly. There were two patients with identical names and the prescription had been issued to the wrong one following the patient attending the practice without an appointment and requesting a prescription from the reception staff. The prescription was wrongly issued in a hurry and when the mistake was realised, contact was made with the patient and the prescription cancelled. The incident was discussed in the practice meeting and a system of double checking names by reception staff was introduced in order to avoid the incident reoccurring.

Overview of safety systems and process

At our last inspection on 18 May 2016 we found some improvements in the systems to monitor risks to patients. However we found further concerns at our 14 June 2017 inspection in relation to arrangements for managing medicines.

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- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. However the child protection policy did not clearly outline who to contact for further guidance if staff had concerns about patients welfare. There was a lead member of staff for safeguarding, however there was no evidence that GPs attended safeguarding meetings or provided reports where necessary for other agencies. We were informed that there were four children currently on the practice child protection watch list and that the practice, however when asked the practice were not aware of any patients that needed to be placed on the list. Staff demonstrated they understood their responsibilities and all staff had received training on safeguarding and

vulnerable adults relevant to their role. GP's were trained to child protection or child safeguarding level 3, the nurse had received level 2 training and administrative staff had received level 1 training.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check.
- The practice was maintaining appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice manager was the infection control lead who liaised with local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place along with cleaning schedules and staff had received up to date training as had the practice manager who had received specific training for the role of an infection control lead within general practice. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- At the last inspection arrangements for the nurse to prescribe medicines such as vaccinations had improved. Patient Group Directions (PGDs) had been put in place and there was a process in place to ensure they were kept up to date. (These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- At the last inspection we found that the arrangements for managing medicines (obtaining, prescribing, recording, storing, security and disposal), in the practice were not always safe. This unsafe practice continued and was evident at the June 2017 inspection. Although the practice carried out regular medicines audits; with the support of the local CCG pharmacy teams and used the QOF (Quality Outcomes Framework) for identifying those patients on a long term register, during this inspection we found there was a lack of a failsafe system in place for ensuring that all patients had an appropriate review for their medicine in line with specific published guidance. Since the last inspection the practice had reviewed its processes to place medicine review dates on prescriptions, however some prescriptions we found did not have a review date. The practice was also using an automatically generated number system on the computer records (counting the number of issues before calling for a review), therefore there was confusion over what system was being used and we found that patients were being issued more than their allocated amount of medicine and there was also evidence of prescriptions being issued after their review date with no review taking place. This meant that the lead GP could not be sure that all patients requiring medication reviews were being reviewed at an appropriate interval subject to recommended guidelines. At our inspection on 14 June 2017 we found 39 prescriptions dated from July 2016 to February 2017 which was in the prescription box at reception ready to be collected by patients. At our inspection on 19 June 2017 there were 26 out of date prescriptions that had not been followed up or destroyed. The reception team were unable to account for the location of 13 other prescriptions which had been identified at the inspection on 14 June 2017. These prescriptions included a number of prescriptions for Tramadol and Temazepam which are controlled drugs. There was a risk that patients would receive medicines that were not appropriate for their current needs due to old prescriptions being given to patients and this not being identified within the pharmacy setting prior to dispensing. Patients on high risk medicines were at risk of harm because if the prescription was not collected by the patient, these patients were not followed up by the practice. Since the inspection the lead GP has provided evidence of attendance at a controlled drugs training course and has stated that changes are being implemented within the practice. We also acknowledge that prescription policies have been reviewed since the inspection.
- At the previous inspection in May 2016 concerns were raised over the practice's handling of high risk medicines and in particular Methotrexate and Sulphasalazine (medicines commonly used to treat severe rheumatoid arthritis (RA) as well as other specific conditions). At this inspection these concerns remained. As part of our inspection we sampled a number of patient records for review and found examples of unsafe care. It was evident that national clinical guidance was not being followed in all cases. We found six examples where Warfarin (used for thinning the blood to avoid clotting) was not being appropriately managed where the patients INR was not being recorded and many patients were being prescribed a fixed dose rather than the dosage being linked to the last INR reading.

(International normalized ratio: A system established by the World Health Organization (WHO) and the International Committee on Thrombosis and Haemostasis for reporting the results of blood coagulation (clotting) tests). Safe prescribing for Methotrexate includes the prescribing and dispensing of only one strength tablet (usually 2.5mg) to avoid confusion by the patient and possible overdose. Due to side effects of the medicine, it is recommended that a folic acid supplement is prescribed..We found six examples where patients were either prescribed a mixture of tablet strengths, not prescribed folic acid or follow up appointments being recorded in the notes. Since the inspection, the practice had introduced the prescribing of 2.5mg tablets for methotrexate and stated that some patients buy folic acid over the counter therefore it is not recorded within their notes. There were four examples of patients prescribed ACE inhibitors (Angiotensin converting enzyme inhibitors) not being effectively managed. This included no record of blood tests being routinely taken. For one patient a combination of Ramipril and Irbesartan was prescribed. The British National Formulary (BNF) stated that these medicines should not be prescribed together as it posed a risk to kidney function. There was no clinical rationale recorded in the patient's notes to explain why this combination was being used and no evidence of this being raised with the patient and consent gained.

- We reviewed two personnel files for the most recently recruited staff members and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice had a system of checking the suitability of locum GPs, however the GP that attended to cover a session on a Wednesday had not received an appraisal.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available with a poster in the reception area which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had put a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. The practice had not undertaken a full legionella assessment (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) but do monitor water temperatures.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

At out inspection in August 2015 we found that the practice had not developed arrangements to deal with emergencies. At this inspection we found that the practice had developed effective arrangements in order to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator and staff had been trained to operate it. Oxygen had been made available with adult and children's masks. Checks were in place. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 18 May 2016, we rated the practice as requires improvement for providing effective services as the arrangements as the systems for reviewing pathology results were not robust and clinical audits were not being used effectively.

The arrangements for handling pathology results had improved when we undertook a follow up inspection on 14 June 2017 however we found that audits were still not being used effectively, GPs were unaware of up to date guidance and there was a lack of awareness over mental capacity guidelines.

Effective needs assessment

Not all of the clinical staff assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice system in place to keep clinical staff up to date was not effective. Staff had access to guidelines from NICE however we were not assured from both our interviews with the GPs and the review of patient records, GPs had read or implemented relevant nationally recognised guidance, particularly in relation to medicines management. Guidelines were printed off by the practice manager for the clinical staff but there was no process to ensure staff had read, understood and implemented guidance following its receipt.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results 82% of the total number of points available. (CCG average 94% and the national average was 95%), with 2.9% exception reporting (CCG average 5.2% and national average 5.7%). Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Data from 2015/2016 showed:

- Performance for diabetes related indicators were mainly below and some significantly below the CCG and the national average and the provider had not taken any steps to address this. For example:
  - The percentage of patients in whom the last blood sugar level was 64 mmol/mol or less was 55%, compared to the CCG average of 77% and the national average of 78%. The practice excepted 4% compared to the CCG rate of 10% and the national rate of 13%.
  - The percentage of patients in whom the last blood pressure reading was 140/80 mmHg or less was 82%, compared to the CCG average of 76% and the national average of 78%. The practice excepted 1.2% compared to the CCG rate of 10% and the national rate of 9%.
  - The percentage of patients whose last measured total cholesterol was 5 mmol/l or less was 65%, compared to the CCG average of 78% and the national average of 80%. The practice excepted 4% compared to the CCG rate of 9% and the national rate of 13%.
- Performance for mental health related indicators were in line with the CCG and to the national average. The practice excepted no patients for these indicators. For example:
  - The percentage of patients (13 patients) with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented was 100%, compared to the CCG average of 91% and the national average of 89%.
  - The percentage of patients (four patients) diagnosed with dementia whose care had been reviewed in a face to face review was 100%, compared to the CCG average of 85% and the national average of 84%.
- Performance for other health related indicators were comparable to the CCG and the national average. For example:
  - The percentage of patients with atrial fibrillation with CHADS2 score of 1 who were currently treated with anticoagulation drug therapy or an antiplatelet

therapy was 94%, compared to the CCG average of 83% and the national average of 87%. The practice excepted 11% compared to the CCG rate of 13% and the national rate of 10%.

- The percentage of patients with asthma who had an asthma review that included an assessment of asthma control using the RCP three questions was 83%, compared to the CCG average of 76% and the national average of 75%. The practice excepted 2.4% compared to the CCG rate of 2.6% and the national rate of 7.9%
- The percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale was 94%, compared to the CCG average of 92% and the national average of 90%. The practice excepted 6% compared to the CCG rate of 7% and the national rate of 12%.

The provider had taken steps to establish a quality improvement system and had completed a two cycle audit for patients with diabetes. However it was difficult to ascertain what improvements had been made to the care of patients. When interviewed, the GP could not give a clear response other than stating that the patients would be referred on to other services.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long term conditions. For example the practice nurse had recently undertaken a diabetes management course.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by attending an annual update and by accessing on line resources.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, and two monthly supervision meetings. All non-clinical staff, practice nurse and regular GPs had received an appraisal.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included medical records and investigation and test results.

From the sample of eight documented examples we reviewed we found that the practice did not always share relevant information with other services in a timely way. We found examples where there was confusion in the responsibility of the care for patients on high risk medicines between the practice and secondary care services. We found eight patient records where care plans were not in place for patients that needed them.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record.

Consent to care and treatment

We were not assured the practice sought patients' consent to care and treatment in line with legislation and guidance.

- < >taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity

to consent in line with relevant guidance. The lead GP showed a lack of awareness for Gillick and Fraser competency. We were therefore not assured when providing care and treatment that relevant consent was being sought as the practice would expect a parent to be present before consent was sought.

- Where a patient's mental capacity to consent to care or treatment was unclear the practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. For example, within the notes of a patient with learning disabilities there was a smear disclaimer written by the practice which was signed by the patient to indicate that they did not wish to receive a smear test. There was no record within the patient's notes of an assessment of the patient's capacity or ability to give informed consent for this decision.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice nurse provided advice to patients on their diet and smoking cessation. The GP's at the practice were able to make referrals to relevant services such as the dietician and smoking services.

The practice's uptake for the cervical screening programme was 79%, which was comparable with the national average of 82%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds was 85% and five year olds was 90% compared to the national standard of 90% for both age ranges.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice provided information about the cervical screening programme in different languages and ensured a female smear taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

At our previous inspection on 18 May 2016, we rated the practice as good for providing caring services. At this inspection we found that there were no care plans in place for patients that had a learning disability or had a long term condition.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 55 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to the national average with its satisfaction scores on consultations with GPs and nurses. for example:

- 83% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 75% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. However, our review of patient records found there was a lack of care plans in place for patients that required them.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with the local and national averages. For example:

- 85% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Good

Are services caring?

Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 41 patients as carers (2% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 18 May 2016, we rated the practice as good for providing a responsive inspection.

When we inspected on 14 and 19 June 2017 we found that there was a poor understanding of the practice complaints policy and procedure and that complaints were not being recorded appropriately.

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered an extended hour's clinic on a Tuesday evening until 7.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability or with complex health needs.
- Home visits were available for older patients and other patients that would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There was a ramp and disabled toilet facilities on the premises and all consultation rooms were located on the ground floor.
- The practice had a hearing loop for patients with a hearing difficulty.

Access to the service

The practice was open between 8.30am and 6pm on Mondays and then Wednesday to Friday and between 8.30am and 7.30pm on Tuesday. Appointments were available between 9am and 11am and 4pm and 6pm Monday to Friday with extended hours to 7.30pm on a Tuesday. In addition, pre-bookable appointments were available up to six weeks in advance and urgent appointments were also available for people that needed them. Nurse appointments were available on a Monday, Tuesday, Thursday and Friday between 9.30am and 12.30pm and between 4pm and 6.30pm on a Thursday.

National GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 68% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and the national average of 76%.
- 79% of patients said they could get through easily to the practice by phone compared to the CCG average of 66% and the national average of 73%.
- 73% of patients described their experience of making an appointment as good compared to the CCG average of 70% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- Whether a home visit was clinically necessary; and
- The urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

Following our inspection on 26 August 2015 the practice was rated as good for providing responsive services. However, at our inspection on 18 May 2016 we found that the complaints system did not take into account of all complaints received both verbal and written. At our inspection on 14 June 2017 we saw that the complaints policy had been changed and was now taking into account both verbal and written complaints.

At the 26 August 2015 inspection we asked to look at complaints received in the 12 month period prior to the visit and we were informed that the practice had not received any complaints over that period. However, through our discussions with staff we noted that there was a lack of awareness in regard to the requirement to record and analyse complaints. At the inspection on 14 June 2017 we found that despite the complaints policy being changed the awareness of the staff still remained the same.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Complaints were being received by the practice but staff were unclear whether they should be recorded as a complaint or a significant event. We found evidence where a recorded significant event would have been better placed as a complaint, therefore not dealt with appropriately. Staff said that verbal complaints were dealt with by the practice manager; however these were not being recorded as per the practice policy.

Are services well-led?

Inadequate

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

Our findings

Following our inspection on 26 August 2015 the practice was rated as inadequate for being well led. We found that not all of the provider's policies and procedures had been customised to reflect the practice's own arrangements and there was no quality improvement programme in place. There was no method of identifying, recording and managing risks, for example infection control. Records were not maintained of clinical and staff meetings.

At our inspection on 18 May 2016 improvements had been made, however further areas of concern were identified and key improvements were still required. During this inspection we identified concerns in relation to safe prescribing practices. For example, in how the practice reviews and reauthorizes prescriptions for medicines. We also found some concerns in relation to the pathology management process finding that test results were not being actioned promptly.

At our inspection on 14 and 19 June 2017 we found that some improvements had been made in regard to the timeliness of actioning test results. However we still found issues with record keeping, prescription management and the management of vulnerable patients. We were not assured that the practice maintained accurate, complete and contemporaneous records in respect of each patient. We reviewed eight records and found examples of poor record keeping and that there was a lack of care plans in place for patients that needed them. Since the inspection the lead GP undertook record keeping training in September 2017 in order to improve the quality of records within the practice.

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes. The practice's aim and objectives were set out in the practice's statement of purpose. The practice had initiated the development of a strategy and supporting business plan, however this was being fully implemented as not all staff understood how their role contributed to achieving the strategy.

Governance arrangements

The practice had taken steps to establish an overarching governance framework however it was not effective. The practice had produced a clinical governance policy.

However, although the practice team had taken steps to manage risks, systems and processes failed to identify issues such as medicines management, including prescription management and monitoring of patients on high risk medicines, care planning and record keeping to ensure systems are failsafe. The information used to monitor performance of these areas was unreliable and out of date. The practice did not have a quality improvement programme. Some clinical audits had been undertaken; however it was unclear how this improved outcomes for patients. Audits were in need of review to ensure they were of clinical value.

The practice had a clear staffing structure and practice specific policies and procedures were available and implemented by staff.

Leadership and culture

The GP and practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. Staff told us that practice leads were responsive to concerns identified at the last inspection and took some action to make improvements, although further action was needed Staff told us that increasing capacity in its administrative team had given the practice manager more time to focus on governance areas. However the GPs were out of touch with what was happening on a day to day basis and there was a lack of clarity of decision making for some areas of the practice.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice encouraged a culture of openness and honesty. Practice leads gave affected people reasonable support, truthful information and a verbal apology where necessary. We noted that there was a complaints policy in place, however the practice had not recorded any written complaints prior to this inspection therefore were unable to demonstrate compliance with the requirements to provide a written response.

There was a leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.

Are services well-led?

Inadequate

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings.

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

The practice encouraged and valued feedback from patients, the public and staff. The practice had established a Patient Participation Group (PPG). The PPG was active in the campaigning for disabled parking bays to be placed outside of the practice for the use of patients. The practice was working through an action plan to improve patient input in the practice. The action plan included:

- Ensuring that patients understand discussions on their condition and treatment. This was an area that was highlighted in their patient survey in 2016.
- To encourage people to take part in the PPG.
- To find out if patients understand the complaints procedure.
- To issue a patient questionnaire for 2017.

The practice had gathered feedback from staff through staff meetings, appraisals, fortnightly one to one meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was limited focus on continuous learning and improvement within the practice.