Care Standards

The Tribunal Procedure Rules (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

Heard on 18-21 September at Royal Courts of Justice, London

BEFORE
Mrs J Crisp (Judge)
Mrs J Cross (Specialist Member)
Mr M Cann (Specialist Member)

BETWEEN:

Dr Surendra Kumar Dhariwal

Appellant

v

Care Quality Commission

Respondent

[2017] 2934.EA

DECISION

1. The Appellant appeals pursuant to section 32(1) of the Health and Social Care Act 2008 against the notice of decision made by the Respondent dated 3rd January 2017.
2. The Notice of Decision confirmed the Respondent's decision to cancel the Appellant's registration as a provider of regulated activities at Manor Park Medical Centre.
3. The Appellant appeared in person and the Respondent was represented by Mr. Pravin Fernando of counsel.
4. The Appellant was registered by the Respondent on 1st April 2013 to provide the following regulated activities

(i) Diagnostic screening

(ii) Family planning

(iii) Maternity and midwifery services

(iv) Surgical Procedures and

(v) Treatment of disease, disorder or injury

BACKGROUND

5. The Appellant is registered as an individual and operates a single handed GP practice at the above location. At the start of the hearing the Appellant advised that he was not seeking continued registration in respect of surgical procedures or midwife and maternity services.

6. An initial inspection carried out by the Respondent was undertaken on the 29th June 2016 by Clare Cunden (Inspector), Dr. Obaidullah(GP Specialist Advisor) and Mr. Lockwood GP Practice Manager Specialist Advisor).

7. There were significant concerns raised in the inspection report and the overall result was inadequate. Specifically are services safe, effective and well led were rated inadequate and are services effective and caring rated requires improvement.

8. As a result of the inspection the Appellant was placed in special measures and a number of breaches of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 were identified.

(i) Regulation 11 (1) Need for consent

(ii) Regulation 12 (1) Safe care and treatment

(iii) Regulation 15 (1) (2) Premises and equipment

(iv) Regulation (17) Good governance

(v) Regulation (18) (2) Staffing

(vi) Regulation 19 (3) Fit and proper persons employed.

9. The Appellant responded to the notice submitting there were no clinical shortcomings and no harm sustained by any patient.

10. James Mullin, Head of Inspections upheld the decision.

11. The Appellant subsequently submitted an action plan on the 29th November 2016 which resulted in a stay in the proceedings to enable the Respondent to conduct a further inspection.

12. This inspection was conducted by Clare Cunden, Sian Jopling (Inspector), Dr. Hin (GP Specialist Advisor) and Mr. Lockwood. This inspection resulted in a further inadequate ratings for safe, effective and well led; requires improvement for caring and good for responsive. The Appellant remained in special measures and there were still breaches of regulations 12 (1); 17(1); 18 (2) and 19 (3).

13. Directions were given during the course of the proceedings by Judge Khan and the case listed for final hearing on 18th – 22nd September 2017.

14. On the 3rd July 2017 an unannounced inspection took place conducted by Clare Cunden, Dr. Hin and Antonia Makinde (Practice Manager Specialist Advisor). This inspection provided a rating of inadequate for all services and continued breaches of regulations 12 (1); 15 (1) (2); 17 (1); 18 (2) and 19 (3).

15. The CCG had subsequently put in place a Practice Manager on a short term basis to endeavour to remedy the failings and she was responsible for writing the most up to date action plan.

LAW

16. Regulation 12.—(1) Care and treatment must be provided in a safe way for service users.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—
(a) assessing the risks to the health and safety of service users of receiving the care or treatment;
(b) doing all that is reasonably practicable to mitigate any such risks;
(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
(d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;
(e)ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;
(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;
(g) the proper and safe management of medicines;
(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;
(i)where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. —

Regulation 15 (1) All premises and equipment used by the service provider must be—
(a) clean,
(b) secure,
(c) suitable for the purpose for which they are being used,
(d) properly used
(e) properly maintained, and
(f) appropriately located for the purpose for which they are being used.

Regulation 17 (2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.
(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—
(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;
(d) maintain securely such other records as are necessary to be kept in relation to—
(i) persons employed in the carrying on of the regulated activity, and
(ii) the management of the regulated activity;
(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;
(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). 18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

Regulation 18 (2) Persons employed by the service provider in the provision of a regulated activity must—
(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,
(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
(c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

Regulation 19.—(1) Persons employed for the purposes of carrying on a regulated activity must—
(a) be of good character,
(b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and
(c) be able by reason of their health, after reasonable adjustments are

made, of properly performing tasks which are intrinsic to the work for which they are employed.

EVIDENCE

17. The Tribunal heard oral evidence from 6 witnesses including the Appellant and considered the written statements of other witnesses.

18. The Appellant's oral evidence was from himself and three patients who were all members of the Patients' Participation Group. Written evidence was from two members of the practice.

    The Respondent's oral evidence was from Clare Cunden, Sian Jopling, Michele Golden (Head of Inspection for General Practice London) and Neil Hamer (CCG). The written evidence was from Dr. Hin, Dr. Obaidullah, Antonia Makinde, Mr. Lockwood and James Mullin.

19. Clare Cunden said prior to the initial inspection she had been made aware that there had been a referral to the GMC regarding the Appellant. It was subsequently accepted that the initial conditions which had been imposed were withdrawn and replaced with a warning in place from 14th November 2016 to 13th November 2021. There had been issues identified during external audits undertaken by infection control lead nurses with the latest being dated June 2016 identifying multiple ongoing concerns. Infection compliance had fallen from 78% in June 2016 to 69% in July 2016 and urgent action was required.

20. Clare Cunden's evidence was that she had been on each of the three inspections and on each inspection concerns had been raised. Whilst some improvements had been made overall the practice still failed to meet the necessary standards.

21. On her initial inspection the premises were cluttered, carpets were stained and there was on the premises out of date equipment. There was no oxygen in the event of a clinical emergency if a patient needed it. This caused an urgent letter to be sent to the practice requiring action on 8th July 2016 which could have caused significant harm.

22. No checks had been carried out on emergency equipment to ensure it was fit for use. There was no list of clinical equipment for calibration and some items including baby scales had not been calibrated for over a year. There was no fire action signage anywhere in the practice. Clinical trolleys were open and accessible with sharps, hazardous liquids and out of date items. The practice did not have a record of significant events. Those which had taken place had not been written up.

23. On cervical screening on the first inspection there was no system in place to check the results of the tests from the lab. Two tests in

February 2016 that needed repeating in 3 months had not been followed up. One was recorded as February 2019. A patient's mis labelled test result had not been picked up as a significant event. There was a high rate of DNA for cervical testing.

24. There was no chaperoning policy, although the Appellant said he had one it could not be produced. He had told her that if anyone asked for one the reception staff did it however the last one was about 2 years ago. The clinical staff is all male and therefore she would have expected a policy to offer such a service. There were no documented records showing when one had been offered and refused and those who had acted as a chaperone had not written anything on the patient's records. No staff had been trained and none had DBS checks.

25. The practice did not operate a two cycle audit to consider best practice. The measurement therefore of where they were on the first audit was not able to be checked to see how effective it was if the second cycle did not take place.

26. The needle stick and splashing protocol had not been updated since 2003. Under cross examination from the Appellant he asked whether she was aware that there had not been an update since 2003. Her evidence was that the telephone numbers of who to contact were not in use and had not been updated.

27. The business plan which was produced subsequently was clearly for another practice as it referred to partners, partnership agreements etc. where none were present. The staff was not involved in governance, although one member of staff was said to take part of the practice manager role she had no idea she was responsible.

28. The nursing home the practice provided a service to had contacted them with several concerns which were the patients did not have prescribed to them liquid medication; the dressings were not sufficiently supplied for grade 3 sores; the food supplements were not prescribed; end of life care did not involve the GP; repeat prescriptions were not issued and that when staff wanted someone they could refer to the Appellant did not return telephone calls.

29. On the second inspection the system for checking cervical screening was still not in place although the Appellant said he checked all results fortnightly but again no records were produced to substantiate it. On checking the records an abnormal result was found which had not been followed up. On the final inspection of the previous 11 results which had not been received and which were notified to the Appellant in March 2017 still 7 had not been chased and remained outstanding.

30. On the 3rd July inspection which was the third inspection the PAT testing had been undertaken but several items which had failed safety testing were in use including a fan with bare wires plugged in situated

in the waiting room and a fan heater that was visibly melted. There was still no inventory of clinical equipment, most had been checked to see if it was working properly but some had not been checked since 2014 including a blood pressure monitoring machine, weighing scales and height meters.

31. The fire exit was deadlocked and a key could not be found. One member of staff said it had been missing for 2 weeks. It was found the day after the inspection behind a file. Signs for fire action were re affixed to the wall by her as one had fallen onto the floor.

32. Fire drills had apparently been carried out but no documentation was available to confirm the position and the Appellant was unable to say when it had taken place. She subsequently received a hand written note dated 21st March. The fire extinguishers were overdue a service and there was no system to ensure future checks. There was no fire marshal to take the lead effectively in the event of a fire.

33. In a room which was unlocked there were numerous safety concerns, the room was packed high with items which had failed electrical safety testing. There was a trolley full of out of date medications including adrenaline expired 2002, Ventolin 2001, furosemide 2006 and 1994, hydrocortisone 2001 amongst others some dating back to 1984.

34. In the clinical treating rooms expired items were present such as sharps which had expired in May 2017, nebuliser masks 2016 and medical wipes 2005. Peak flow meters were obsolete. One of the thermometers in the medicine fridge was out of range by 1 degree at 9 degrees.

35. In her view there was no assurance that the staff present understood any infection control practices and also the Appellant did not understand the implications of safety to his patients.

36. There was no evidence as to how staffing cover was organised. On one attendance one member of staff did not arrive for the later shift and there was no rota or staff cover provided.

37. In her opinion a practice manager would be required full time as there were no or limited procedures in place and there would need to be a complete review of all working practices as every element of the practice would need to be considered.

38. At the final inspection there were still gaps in DBS checks although some were presented subsequently.

39. Sian Jopling attended the March inspection. She said the trolleys were still cluttered and dusty despite the improvements mentioned by the Appellant. Pre swab wipes expired in February 2017, capillary tubes January 2010 and 2 easy haler inhalers were dusty and unclean. In her

view it would be difficult to find things on the trolley and it would compromise patient safety.

40. There was no system in place to get rid of expired items and some expired items were still in place when she attended despite the previous concerns raised in June.

41. She accepted there had been a recent infection control audit and there were improvements however the failure on Standard 1 was a consistent theme and the failure on Standard7Q1 was significant and constant. It was the legionnaire assessment which had no written procedure and was a danger to staff and patients. Her concern was there was still no monitoring in place and there would be a lack of sustainability going forward.

42. Dr. Obaidullah's written evidence was that when he attended on 3rd July emergency medicines had expired. There was out of date adrenaline, no rectal diazepam and the glucagon injection was expiring on the day of the inspection. He found no system in place to check expiry dates for medicines or replacements. His general conclusion was the practice was inadequate in the domains of safe, effective, and well led patients care but adequate in caring and required improvement in responsiveness.

43. Dr Hin looked at records in July 2017 and noted that 2 patients where blood tests needed to be undertaken regularly with his suggestion of 3 – 6 months that one patient had not had any testing for over a year.

44. Soluble aspirin was not present when he checked emergency medication which would be used in the initial management of someone with a potential MI. There was no evidence of a log of monthly checks of emergency medication but the drugs were in date.

45. Michele Golden said she became involved in the case in July 2016 after the initial visit. She had not visited the practice herself. She confirmed that the CQC could only take action against breaches of regulation. If there was a cross over in the breaches they would not take action i.e. if someone was found to have failed by one action both in respect of patient care and premises.

46. She gave evidence that the cervical screening was concerning. 3% of small cell carcinomas are very aggressive. In the patient that should have received a follow up smear this was noted for follow up in February 2019 instead of 3 months after the initial test and that the patient could have died.

    The CQC followed procedure when deciding whether to take enforcement action. They would look at the impact of the breach which she said would be classed as major; then consider the likelihood of it happening again which she believed was probable due to the number

not having tests chased up or non-attendances. When one then placed the major breach with the probable likelihood that would return an extreme likelihood it would happen again. This together with the failure to act on past risks and persistent breaches led her to the decision that required either urgent cancellation; suspension or imposition of conditions.

47. It was her evidence that the practice could not operate under conditions as these would prevent the Appellant from practising. She said that there was no adequate leadership or governance shown by the repeated failures over 3 successive visits.

    The problems at the nursing home were still not addressed and the Appellant had not arranged a meeting as suggested on his action plan for over 6 months. All of the above issues led her to the view that the service provided was not safe, effective, caring, or well led all of which would lead to breaches of the regulations.

    The action plan did not give her any confidence that it would be implemented and sustained due to the past history. There was no one taking responsibility, the Practice Manager had been installed as a temporary measure by the CCG and the Practice Nurse was only a locum due to the absence of the permanent member of staff for over 3 months.

48. On each of the three occasions the practice had been inspected there were breaches of regulations and the systems therefore if they were in place were not working. Whilst an action plan had been presented there was still no female GP, Practice Nurse or Practice Manager.

49. Neil Hamer has responsibility for primary care for GPs in the area. He accepted that Newham had a particular challenge in respect of breast and cervical screening but that the practices were supported and encouraged to assist their patients in attending.

    The CCG were in support of the decision of the CQC and the patients would be covered either by other practices or initially by out of hours if the appeal failed. He said that it was accepted that the practice had a higher need from the demographics of the patients but nevertheless the Appellant's practice only had 1250 patients which had declined over the last 4 years and standard GP practices had 2300 patients.

50. Surinder Gautama gave evidence in behalf of the Appellant. He has been a patient for over 41 years and is on the PPG. He confirmed his written evidence that he had never had cause to complain. The surgery was always neat and tidy and the other patients to whom he had spoken were similarly very satisfied with the practice.

51. He was asked in cross examination about the meetings and specifically what the policy was regarding complaints. He said he was not sure

who dealt with complaints, probably the GP. He did not know what the policy, if there was one, said. With regard to the patient survey he confirmed it had only been handed out to the patients who had attended the practice.

52. Dr. Dhariwal had not provided a statement of evidence but the panel admitted his evidence which was not opposed by the Respondent.

    He confirmed that he had been working in the NHS since 1965 and had worked for 48 years in the same practice. He said he loved his work, still loved it and would find it difficult if he was not allowed to practice.

53. His patients were looked after and he had high scores on patient satisfaction. He did not accept that his patients would be accommodated easily by Newham CCG. His staff and other patients had written in support of not closing the practice down and he had hardly any complaints.

54. He had produced an action plan and therefore it would not be proportionate to cancel his registration.

55. He said that all the policies and procedures were now in place and he intended to employ a practice manager although it had been difficult to find one. The Practice Manager would be employed for 10 hours a week and he produced an unsigned contract from Newham providing those services. He had not managed to employ a female GP or a nurse and his Practice Nurse was on extended leave but there was a locum present. The appointments with the nurse were not always filled.

56. He had undertaken cervical screening for many years. He did try and encourage patients to attend for screening but ultimately it was their choice. He was asked about the failure to chase up results on screening and said it was the responsibility of the nurse but could not say whether she had checked it or not. He did say it was a surprise to him when he found out how many had not been received. He did not know where that might be documented.

57. He accepted that missing a MHRA alert was a significant event and he confirmed it had been written up. He produced the next morning copies of the significant events. He did not accept however the advice re regular testing on the other MHRA advice and said that annually was sufficient.

58. He did not accept the concerns of the nursing home. He said he would not do repeat prescriptions as the patient might not need a repeat prescription. He said the dressings for chronically ill patients were expensive and the advice was not to use for over 4 weeks. The problems with prescribing was due to part time staff at the home and duplication of work.

59. Food supplements would not be given by him unless the patient had a BMI under 17. He had suggested using dried milk as a supplement which he said was endorsed by the dietician.

60. He stated that significant events were recorded and the reason the inspectors could not find them was that they were on different computers. They were discussed at practice meetings which took place every 3 months. He accepted that he had missed the MHRA alert regarding the defibrillator and had recorded that as a significant event.

61. He said it was his view that missing alerts, blood tests or cervical screening results would not be recorded as significant events unless that patient had suffered harm.

62. On the recent infection control visit (6/9/17) the figure was 97% compliance. He said there were only 3 things raised as an issue, sharps policy, temperature on the fridge and the MMR status of some employees. The only thing he was requested to do was to change the taps. The remainder of their concerns were alleviated when he produced documents following the visit.

63. He did not accept the trolleys were cluttered and said he needed all of the items contained therein.

64. The equipment which had failed PAT testing was not in use. He had stored it in a room and had no idea why it was in the reception. He accepted it was in use and plugged in. He said it was not dangerous to children as they could not reach the plug and only when put to him by the panel he accepted in his own notes of the practice meeting he had referred to it as dangerous.

65. He said the fridge did have three thermometers as they all showed different temperatures and therefore the practice needed 3 to average out the temperature.

66. He could not explain if there was a procedure in place to dispose of out of date medication why at the last visit out of date medicines were found by the inspectors. He said there was a list with dates on and it was checked every month and had been for the last 5-6 months.

67. He produced DBS checks for all members of staff except the practice nurse who was on extended leave. He said the staff know the procedures for staff cover and it is in the business continuity plan.

68. He was asked about the significant events and said they were discussed at meetings although accepted that the locum GP would not always be present. He could not provide an explanation as to why the significant events had two numbered 03.

69. He had wished to merge with another practice and still wished to have time to do so.

70. He accepted in submissions that he took responsibility for the breaches in his practice, he had ignored his role as a Practice Manager and was ignorant of the up to date requirements of the CQC. He had a high prevalence of elderly and chronic disease patients and had recorded a high achievement on the recent QOF. He had attended 8 workshops on the resilience programme and it was his view that the CCG should have offered assistance earlier. All of the patient surveys they had conducted were very positive and only 1 had said the service was not good all of the others would recommend him.

FINDINGS

71. On each of the three inspections medicines were found in clinical treatment rooms which were out of date. On the 3rd July inspection there were numerous medicines which were out of date some contained in a store room and not disposed of dating back several years. In clinical rooms it was accepted that there were medical wipes which were out of date (2005), nebuliser masks (2016) and sharps 2017. There is nothing in place on the practice report plan by way of a system to ensure that all medicines are recorded and details of expiry dates entered on a log by way of example which would be checked.

72. We find that the practice has failed to dispose of out of date medication and has continued to have out of date medication within treatment rooms which is a significant risk to patients. There is no system or identification of who would be responsible for ongoing monitoring.

73. Further the panel find as this was not challenged that emergency medicine was out of date and there was no rectal diazepam or soluble aspirin. The emergency oxygen masks for adults and children were not present on the date of the initial inspection on 29th June 2016. Despite having raised this as a serious concern with the Appellant he had not acted on it which caused the Respondent to write on the 8th July saying urgent action would be taken if the practice did not confirm it had obtained the oxygen and masks by 12th July. On the 12th July the practice wrote and advised they were in place.

74. We find this is a serious omission and concerning that it took a formal letter before the Appellant rectified the omission.

75. The practice had not acted on the MHRA alert regarding the defibrillator which was subject to a recall and not checked until identified at the inspection. We find that the response regarding recording this as a significant event is late and ineffective. The event was identified on the 22nd March and not recorded until the 10th April. The Action Plan did not identify how future alerts would be managed and how details would be cascaded to staff including the locum GP who did not attend practice meetings. The practice plan report

suggests there is a safety alert policy in place. In the recent practice meetings although drug alerts are a standing item there are none recorded from April to September. The practice plan report identifies sodium chloride bags alert dated 13th July 2017. All of the PM minutes refer to no drug alerts from July to September. It is concerning that no notice of any drug alerts seems to have been acted upon or noted from April to September in the practice meeting minutes.

76. We find that there is not an appropriate policy in place to identify, act upon and disseminate the information to all staff.

77. Equipment has not been checked or calibrated for over a year, this included a blood pressure monitoring machine and baby scales. The practice plan suggests that an inventory has now been written which includes the details of make, supplier, calibration details and responsible person name. This is part of a plan which was written on 30th August 2017. It has not been tested.

78. The panel accept the report of the inspection prevention and control audit report dated 6th September 2017 and note the overall score of 95%. The panel cannot accept the submission of the Appellant that it should be 99% due to documents supplied subsequently as we are not aware as to how the overall score is calculated but note that the 50% mark was due to immunisation details which were said to be supplied after the inspection.

79. The panel find however that the Appellant had not recorded water temperatures to prevent Legionnaires and this was raised as an issue and on the proposed risk assessment dated 2016 which the Appellant had produced confirming it would be undertaken monthly. The panel note that no recording had taken place from 2016 to September 2017. The panel accept the evidence of Sian Jopling that it is concerning that some issues raised regarding infection control have continued since 2011 to date without rectification.

80. The evidence concerning the thermometers from the Appellant is that there were 3 thermometers to check the temperature would not go out of range in the medicine fridge. Whilst it is suggested that the fridge is serviced annually one would question therefore why there would need to be three thermometers or four as were in place in 2014 and five in 2016 all recording different temperatures and that the temperatures had gone out of range.

81. The panel also note that when the Appellant was told to dispose of vaccines in the fridge in 2014 due to concerns raised about the recording of the temperatures he refused.

82. The panel find that the protocol for storage of vaccines was not met and therefore the vaccines had not been stored safely which is a risk to patient safety.

83. The panel find there has been an improvement on Infection Prevention and Control in the audit dated 6th September 2017

84. The panel accept that there are policies in place i.e. fire safety, sharps management, decontamination, hand hygiene etc. When one considers implementation of these policies however it is clear that the policies are not followed. Fire drills are said to take place twice annually and records should be maintained. This was not available at the inspection audit and was subsequently forwarded as a hand written document in contrast to the pro forma contained within their own policy. Further the fire extinguishers had not been serviced for over a year which is a breach of their policy requirements and the fire exit door was locked which again is another breach. We accept the evidence that the key had been missing for at least two days and maybe more, one member of staff said 2 weeks. When it was found it was behind a file which leads to us finding that the exit and the key for use are not stored appropriately. The sharps policy had a poster advising who to contact but the telephone number provided was not in use. The panel further find that the sharps policy is not a document which is readily accessible to staff as at the recent infection control audit it was not able to be produced.

85. The panel accept that in respect of the premises there have been significant improvements which is noted in the recent infection control report. However the equipment which has failed PAT testing remains in situ and the evidence given in respect of the fan is concerning. The Appellant suggested the fan was not dangerous as it was not able to be reached by a child and it was the plug which had failed. When it was put to the Appellant that in his own notes it stated that the wires were loose and it was dangerous he accepted the position although said that it was stored in a store room and should not have been brought back into use.

86. There is again no procedure or policy which is acted upon by the staff for the storage and disposal of equipment which has been failed following PAT testing. The panel accept that it may be that the industry guideline is two years for such testing to take place but one would expect having completed such testing that all failed items should be removed immediately and not used subsequently. Further if the equipment is not to be removed immediately it should be stored in a locked room without access either by patients or staff. This is noted in the minutes of 7th August and no significant event record has been filed. The panel find therefore that no system is effective and the evidence of the Respondent is accepted in respect of the other items which totalled at least 7 which had failed PAT testing were still in use or had not been disposed of.

87. The evidence from the Appellant in respect of significant events (SE) is that there is a folder which contains all the significant events and this is discussed at meetings on a regular basis.

88. When the Appellant was asked to bring to the hearing copies of the documents 6 such documents were provided. There is no clear identification of how those documents are recorded as the numbering contains 2 documents numbered 03 and they are not in chronological order. The SE in respect of the cleaner which had been seen by the Respondent was not within the documents brought. Only one document is completed on the same date and some two weeks later. These documents are not shared with the locum GP as a rule. Some meetings discussed SE for example the meeting on the 4th April in respect of the MHRA alert others did not.

89. The panel find that serious SE have not been recorded i.e. the screening which will be referred to later in this decision or the electrical fan both of which give rise to patient safety.

90. The evidence of the Appellant was extremely worrying. His evidence when asked about why screening failures were not recorded as a SE was that no patient had come to harm so it did not need to be recorded. He accepted the dangerous fan probably should have been recorded.

91. The panel find there is no effective system in place to learn from SE. Clearly all the SE cannot be maintained in one folder as one relating to the cleaner could not be found and further at the inspection on the 3rd July the one dated 10th April was not produced or mentioned by the Appellant. The action plans are not followed up (MHRA alerts) and further the meetings do not include locum GPS except on one occasion. There is no evidence of learning outcomes and how these SE can be avoided in the future.

92. The practice meetings at which these issues are discussed have not taken place regularly until July of this year with a gap from April to July with no meetings and the panel accept the evidence of the Respondent from the 3rd July inspection when it is reported that two members of staff said that the incidents had not been discussed (cleaner and change of name) and no meeting had taken place since February 2017.

93. The cervical screening has been considered by the Respondent on all 3 inspections. In June 2016 the evidence was that two tests in February 2016 had not been followed up. One of those was recorded as not needed to be reviewed until February 2019. There was no system in place for fail safes. There was a high rate of DNA attendances.

94. On the July inspection the evidence was that 11 tests had not been received back since 1st March 2017. The staff had chased 4 after the inspection on 22nd March when this was raised. No further chases had been made. The Respondent ran a further check and noted over 10 years 49 test samples had not been received. There was also an abnormal result received on 8th April which had not been repeated. The practice nurse was not aware of any system in place.

95. The evidence from the Appellant was there was a system in place and it was only 4.9 patients per year that had been missed. He also stated that it was the responsibility of the nurse and he could not say whether she had checked or not and it came as a surprise to him as to the amount which remained outstanding.

96. The panel accept the evidence which is unchallenged and find this is extremely alarming. The failure to follow up important screening results places patients at risk of development of cervical cancer which is life threatening.

97. The panel also find that the failure to report this as a SE is also a significant risk to patient safety and the Appellants comments regarding no one coming to harm are not acceptable.

98. The practice at the initial inspection did not have a chaperoning policy, evidence of DBS checks or training for the chaperones.

99. The Appellant produced details of the policy and subsequent DBS checks for the two chaperones dated August 2017 and details of training attended

100. In July there was evidence of chaperoning but the chaperones had not noted EMIS with their attendance and the lack of staff meant that this could only take place at certain times during the day. There was no record kept of where a patient was offered a chaperone and the offer declined.

101. The panel find there is a breach of the chaperoning policy as set out above also the late obtaining of the DBS checks is a further breach of their policy. The DBS checks are not enhanced checks which although is not a pre requisite is safe practice.

102. The practice has still not completed a two cycle audit and the latest action plan confirms that the first cycle audit has been undertaken on 7th August 2017 13 results still not received. The second has not been undertaken.

103. The panel find that this is another example of failure to maintain safe systems and promote effective learning which is troubling given that the initial inspection took place over 14 months ago.

104. The panel find in relation to the staff that the new practice nurse has not provided details of indemnity insurance, Hep B status or cytology update. The latter is a requirement for cervical screening.

105. The panel accept the other missing documents relating to staff have been provided although the panel are unsure in relation to the practice nurse who is currently on leave and cannot make any findings as she may have a valid one form another practice.

106. The panel find that there is not an effective system in place to provide staff cover. The panel accept that this is a small practice nevertheless the arrangements are haphazard.

107. The practice nurse is away for considerable periods of time and in March earlier this year there was no cover provided. The appointments for the practice nurse were sparse but that may be due to lack of cover previously and patients' expectations.

108. The minutes of the meeting on 7th August detail a request as to whether Jasmin was to cover Thelma from the 25th August to 8th September (the receptionist) as Dixa (secretary) was already on leave. The response was for the staff to look at the updated business continuity plan 2.11. This refers to incapacity of staff and not annual leave.

109. The panel find there is no system in place and the detailed action report plan also refers to the same section in the business continuity plan which is incorrect. There appears to be no consideration of staff leave and two members of staff being off out of three at the same time shows lack of planning. It is also noted that as such there would be no opportunity for a chaperoning service to be provided.

110. The Appellant's evidence in respect of the care home is that he would only prescribe food supplements if the BMI was under 17 and otherwise with the support of a dietician suggested milk powder to be added. The issue concerning dressings was due to prescriptive practices and there was no need to order for in excess of 4 weeks as the dressings should not be prescribed for over that period. His evidence in respect of failure to provide oral medication was that it was not licensed and he did not accept that telephone calls were not returned.

111. The panel find that there are concerns raised by the nursing home such that they are considering appointing another GP. Whatever the position the fact that a meeting was scheduled to be set up following the inspection in March 2017 has still not been set up. This is referred to in the amended detailed action plan and the previous one dated 20th July 2017. It is now the 20th September and still that meeting remains outstanding.

112. The panel find the Appellant has lack of insight in particular the failure to identify SE and this would give rise to concern as to how effective any proposed action plan would be.

BREACHES OF REGULATIONS

113. In the light of the findings above the panel find there is a breach of regulation 12 (1) safe care and treatment.

114. Whilst the Appellant has produced a detailed action plan concerning equipment and stock logs this has not yet been embedded or tested as to implementation.

115. The panel find there is a breach of regulation 15(1) premises and equipment. PAT testing had not been actioned appropriately; fire exit door was locked. The panel accept that the premises have however passed a recent infection control audit dated 6th September 2017 which has addressed some issues.

116. The panel find that there is a breach of regulation 17(1) Good governance. In particular the lack of a safe system for cervical screening; lack of appropriate consideration or effective recording of SE such that the practice could learn from the same; failure to adopt the chaperoning policy, failure to have in place an effective organisational structure. The panel note the detailed action plan and the business continuity plan but the staff members relating to the role of Practice Manager either did not know they were responsible for that role or in the case of the nurse were not present at the practice. In general terms the staff and the Appellant seemed to be unaware of their policies and on occasions could not locate the policy when asked. There seemed to be a general lack of responsibility and awareness of line management and it is concerning that the cervical screening results were left with no one accepting responsibility or being aware of the results which were outstanding.

117. A further example of failure to address good governance is found with the detailed action plan concerning practice meetings. Although there is a template which is being followed there is no consideration of matters arising from previous meetings, actions agreed and a follow up of who is responsible.

118. The panel find there is a breach of regulation 18(2) staffing. The staff which are present are not appropriately supervised or trained and there appears to be a lack of knowledge of important policies and procedures.

119. The panel accept that the Appellant has been trying to recruit a practice manager for a period of time and that an unsigned contract is now available to provide 10 hours each week through Newham Health Collaborative. The panel accept the evidence of the Respondent that to provide the necessary level of support which is required to enable the practice to function safely, at least initially a full time Practice Manager is needed to implement the policies and procedures and ensure their effectiveness in the future. Whilst the panel accepts it may be difficult to recruit the panel note that the email to the Practice Managers' forum is

dated 28th June 2017 nearly a year after the initial inspection which resulted in an inadequate rating.

120. The Appellant recognises and seems to have previously recognised in 2009 that a female GP is required. No evidence has been submitted in respect of any attempts at such recruitment.

121. The panel find there is a breach of regulation 19(3) and schedule 3 fit and proper persons employed. The panel accept that the recruitment checks, DBS checks and indemnity insurance etc. are now in place however the documentation for the locum practice nurse has not been seen and there remains a query in relation to the practice nurse who remains on annual leave.

CONCLUSION

122. The panel has carefully considered the detailed action plan provided by the Appellant dated 30th August 2017. Whilst that document sets out how the practice will remedy the many failings it is clear from consideration of the above findings that many of the proposed plans have either yet to be implemented or have already failed to address the concerns.

123. The panel note that since the 29th June 2016 the Appellant has had the opportunity to address the concerns as set out in the initial report. Despite the Appellant suggesting that all matters had been rectified and this resulted in the second inspection on the 22nd March 2017 it was clear that the failures continued. On the final inspection on 3rd July 2017 the rating was inadequate and stated to be inadequate across all demographics of the practice and each area, safe, effective, well led, caring and responsive.

124. The panel noted that some of the initial concerns were still present at the final inspection a year later. The panel has no confidence that the proposed action plan will address the significant issues.

125. The panel also considered the Appellant's proposal to merge and/ or go into partnership with another practice and there is no evidence that this will be achieved and we accept the evidence of Neil Hamer from the CCG that they have tried to facilitate such a proposal for a period of time without success.

126. The panel wish to record that it is accepted there are no clinical issues and that he has been a longstanding GP offering services to a higher than average patient weighting. It is accepted that the Appellant wishes to continue providing such services and that medicine is his vocation.

127. The panel note the statements from 3 of his patients. All commend his practice and in some cases have been patients for over 41 years. Further the surveys undertaken show positive feedback.

128. The panel also accept that the Appellant in his closing submissions apologised and took responsibility for breaches in his practice as he advised he was ignorant of the up to date requirements of the CQC.

DECISION

129. In the light of the above findings and breaches of regulation the panel feel that it is not disproportionate to cancel the registration.

Judge Judith Crisp
Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 2 October 2017