Dr Saptarshi Saha

Quality Report

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Date of inspection visit: 3 October 2014
Date of publication: 28/05/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We completed a comprehensive inspection at Darlaston Health Centre on 3 October 2014. The overall rating for the practice is that it requires improvement. We found the practice to be good in the caring and responsive domains and requires improvement in the safe, effective and well-led domains. We found the practice required improvement in the care provided to people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health.

Our key findings were as follows:

- Staff were aware of their responsibility to report and record significant events; however there was limited evidence to demonstrate learning and dissemination of information to staff or others who were involved in the significant event. Lessons learnt were not always recorded to ensure that all staff had been made aware of any learning or actions required.
- NHS health checks had only been completed for 9% of the practice population aged 40 – 74 up until December 2013. These health checks are a method used to identify those patients at risk of developing long term conditions.
- Staff were caring and treated patients with dignity and respect.
- Robust systems were in place for handling concerns and complaints. Changes in practice had been made due to lessons learned.
- Staff worked well as a team and good management support systems were in place.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Implement robust recruitment processes to ensure only suitable staff are employed and recruitment processes reflect the requirements set out in Schedule 3 of the Health and Social Care Act 2008.

Summary of findings

- Ensure that staff have appropriate training and support in relation to their duties and roles. Identify and deliver training and awareness to staff to enable them to deliver care safely and to an appropriate standard and provide up to date records to demonstrate that staff have undertaken appropriate training.
- Implement effective systems for identifying, assessing and management of risks to patients and others for example risk assessment and safe systems for dealing with emergencies, staffing and recruitment.

In addition the provider should:

- Review the staff group knowledge and understanding regarding the chaperone process to ensure it reflects the published General Medical Council (GMC) guidance for 'Intimate examinations and chaperones.
- Develop the Incident/significant event reporting, recording and monitoring process to ensure trends and lessons learnt are captured and shared internally, and where appropriate externally.
- Develop systems to demonstrate that medication to be used in an emergency is available and within its expiry date.
- Provide risk assessments and maintenance records which demonstrate that the premises and equipment do not provide a risk to staff or patients.
- Ensure information on how to make a complaint is freely available to patients.
- Make patients aware that a hearing loop system is available at the practice.
- Ensure that the practice's disaster recovery plan provides staff with sufficient information regarding the action to take if there was a loss of services or facilities at the practice.
- Develop systems to obtain patient feedback, for example a patient participation group.
- Ensure patients have access to information about health promotion and support services available.

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?

Requires improvement

The practice is rated as requires improvement for safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses. However, when things went wrong evidence was not available to demonstrate that lessons learnt were communicated widely enough to support improvement.

In the staff files that we reviewed we found that pre-employment checks had not been completed for all areas as required. This meant that staff recruitment processes were not sufficiently robust and may not ensure that appropriate staff were recruited to work at the practice.

Systems and processes in place were not robust and did not ensure that environmental, equipment and maintenance checks were in place. Documentation to demonstrate checks undertaken were not available for review.

The role and responsibilities described by some staff did not reflect the published General Medical Council (GMC) guidance for 'Intimate examinations and chaperones'.

Medication to be used in an emergency situation was available at the practice. The practice did not have a system to ensure that emergency medication was kept within its expiry date.

Policies and procedures were in place to ensure staff had the necessary knowledge and understanding in relation to safeguarding children and vulnerable adults.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective. There was insufficient evidence to demonstrate that all staff had received training appropriate to their roles.

Systems were in place to review the care needs of those patients with complex needs or those in vulnerable circumstances and people's needs were assessed and care was planned and delivered in line with current legislation.

Due to staff vacancies the practice had undertaken a very low percentage of health checks for the 40 – 74 year old patients registered with the service. The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74,

Summary of findings

who have not already been diagnosed with one of these conditions or have certain risk factors, can be invited to have a check to assess their risk and will be given support and advice to help them reduce or manage that risk.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. There was an effective triage system in place. Children requiring an urgent appointment were always offered same-day appointments. Home visits and telephone consultations also took place.

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The lead GP had a vision for the continued delivery of good care and treatment however, this had not been formalised and not all staff were aware of this. Staff felt supported by management but were not always aware who held a lead role.

There was limited evidence to demonstrate that incidents were discussed with staff and information regarding learning outcomes and action taken disseminated.

Systems in place to monitor and improve quality and identify risks were not robust.

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

Requires improvement

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

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

A flexible appointments system was in place for older people, appointments could be arranged around the patient's carer to enable them to attend the surgery.

People with long term conditions

Requires improvement

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

The practice nurse regularly reviewed the long term condition register to ensure patients were reminded when a review of their condition and treatment was required. Referral processes were in place for patients in this group who required specialist support or had deteriorated in their health. The practice worked with other professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

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

Immunisation rates were high for all standard childhood immunisations. Parents of children who did not attend appointments were contacted to remind them of the importance of immunisations and to make another appointment. Appointments were available outside of school hours and the premises was suitable for children and babies.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the population group working age people. The needs of the working age population, those recently retired and students were considered with early evening appointments being available. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. At the time of inspection only 9% of the practice population aged between 40 and 74 had been offered an NHS health check.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people living in vulnerable circumstances. Staff knew their responsibility and could recognise signs of potential abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of service hours. We did not see any evidence to demonstrate that the practice worked with other colleagues regarding vulnerable patients, or those who had been identified as at risk of abuse. A very low percentage of those patients registered at the practice who have a learning disability had an annual review of their health needs.

People experiencing poor mental health (including people with dementia)

Requires improvement

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

Some health care checks were completed for people suffering from poor mental health. Regular review appointments were offered as necessary. Blood tests were offered in the surgery where the patient was unlikely to access phlebotomy services at a local hospital (to draw blood from a patient for clinical or medical testing).

Summary of findings

What people who use the service say

As part of the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received forty seven completed cards with the large majority recording positive feedback and describing all staff as kind and caring and commenting that the doctor listened and explained treatment options well. On the day of our inspection we spoke with four patients. These people were generally happy with the care provided by GPs but commented about long waiting times and difficulty getting appointments to see a GP.

Four patients who provided feedback described difficulties in accessing appointments and one person said that they had not been able to access an emergency appointment. This had also been reflected in the 2013 patient satisfaction survey.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. We saw that both positive and negative comments were recorded. The practice had not responded to comments to give an explanation or to record any action taken to address issues raised.

Areas for improvement

Action the service MUST take to improve

- Implement robust recruitment processes to ensure only suitable staff are employed and recruitment processes reflect the requirements set out in Schedule 3 of the Health and Social Care Act 2008.
- Ensure that staff have appropriate training and support in relation to their duties and roles. Identify and deliver training and awareness to staff to enable them to deliver care safely and to an appropriate standard and provide up to date records to demonstrate that staff have undertaken appropriate training.
- Implement effective systems for identifying, assessing and management of risks to patients and others for example risk assessment and safe systems for dealing with emergencies.

Action the service SHOULD take to improve

- Review the staff group knowledge and understanding regarding the chaperone process to ensure it reflects the published General Medical Council (GMC) guidance for Intimate examinations and chaperones.
- Develop the Incident/significant event reporting, recording and monitoring process to ensure trends and lessons learnt are captured and shared internally, and where appropriate externally.
- Develop systems to demonstrate that medication to be used in an emergency is available and within its expiry date.
- Provide risk assessments and maintenance records which demonstrate that the premises and equipment do not provide a risk to staff or patients.
- Ensure information on how to make a complaint is freely available to patients.
- Make patients aware that a hearing loop system is available at the practice.
- Ensure that the practice's disaster recovery plan provides staff with sufficient information regarding the action to take if there was a loss of services or facilities at the practice.
- Develop systems to obtain patient feedback, for example a patient participation group.
- Ensure patients have access to information about health promotion and support services available.

Dr Saptarshi Saha

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector; the team included a GP, a practice manager and a second CQC inspector.

Background to Dr Saptarshi Saha

Dr Saha's GP practice is located in Darlaston Health Centre which is based in the Walsall Clinical Commissioning Group (CCG) The practice provides primary medical services to approximately 3,300 patients in the local community.

There were three GPs working at the practice. A lead GP (male) who was present during our inspection, a salaried GP (female) and a locum GP who worked regular sessions. Additional staff included a practice manager, one nurse prescriber (female) and a health care assistant (female). There were five administrative staff that supported the practice. One pharmacist also supported the practice twice a week.

The practice offered a range of clinics and services including, smoking cessation, asthma, COPD, Immunisations and Weight Management.

The practice had opted out of providing out-of-hours services to their own patients. This service was provided by an external out of hours service contracted by the CCG.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We carried out an announced visit on 3 October 2014. During our visit we spoke with a range of staff including a GP, nurse, practice manager and administration staff and we spoke with patients who used the service.

Requires improvement

Are services safe?

Our findings

Safe Track Record

There was evidence to show that the practice had a good track record on safety with no history of major incidents. The practice used a range of information to identify risks in relation to patient safety. For example, national patient safety alerts (alerts and notices which are issued to healthcare staff and NHS organisations on patient safety issues, which require urgent attention and/or action). Staff spoken with told us that they received this information via email and were aware that there was a log of safety alerts which could be accessed for future reference. This helped to ensure the safety of patients.

There was evidence that staff were reporting significant events and these had been recorded. Staff were aware of their roles and responsibility for reporting incidents, concerns and significant events. Details of significant events were kept in a folder; but there was limited evidence to demonstrate learning and dissemination of information to staff or others who were involved in the significant event. There was no analysis of the information and data to identify potential trends. Lessons learnt were not always recorded to ensure that all staff had been made aware of any learning or actions required.

Learning and improvement from safety incidents

We reviewed the Practice's system for reporting, recording and monitoring significant events. We found that systems in place were not robust. We saw that significant events were recorded but there was limited evidence to demonstrate that appropriate action had been taken or that any learning had taken place. A significant event could be either a positive or negative event which is important or unusual and provides an opportunity to identify an area for learning or improvement. They could relate to clinical, organisation or communication issues.

We were told that practice meetings took place on a quarterly basis and that complaints and significant events were discussed during those meetings. The minutes of the practice meetings we looked at did not clearly demonstrate that significant events were fully discussed. The standardised significant events forms seen did not record details of any discussions held, the outcome of any investigation/discussion or any learning outcomes. There was no documentation to demonstrate that a review of information had taken place. The practice manager was aware of the inadequacy of the reporting form and made changes to this document during our inspection.

We spoke with the practice manager and a member of reception staff separately. Both were able to recall a recent significant event and discussed the actions taken to try and reduce the risk of re-occurrence in the future. Records seen did not clearly record all actions taken.

Reliable safety systems and processes including safeguarding

We discussed the systems in place for safeguarding vulnerable adults and for protecting children. Staff knew their responsibilities regarding information sharing of safeguarding concerns. Contact details for staff to raise concerns about domestic abuse and child abuse were on display in reception and doctors' rooms. We saw that there were no contact details for reporting concerns of vulnerable adult abuse. Staff spoken with were not aware of the contact details but confirmed that they would ensure that all suspicion of adult abuse was reported to the appropriate agency.

We saw that there was a safeguarding policy which was reviewed on an annual basis. A safeguarding lead was recorded on the policy. There had been no recent safeguarding issues reported to the practice relating to children or vulnerable adults. Forms were available on the computer to enable staff to report abuse. We were told that multidisciplinary meetings regarding safeguarding did not take place.

We saw that signs were on display in treatment rooms advising people that they could ask for a chaperone if they wished. A chaperone can help to provide some protection to patients and clinicians during sensitive examinations. We spoke with staff and identified that they had not undertaken appropriate training or guidance. Some of the staff we spoke with could not clearly explain the correct procedure for acting as a chaperone. The role and responsibilities described by some staff did not reflect the 2013 published General Medical Council (GMC) guidance for 'Intimate examinations and chaperones'.

Staff we spoke with were aware of the processes to follow if they had any concerns about poor practice. We were told that there was a whistle blowing policy which was available

to staff on the practice's computer system Whistleblowing is when staff report suspected wrong doing or poor practice at work, this is officially referred to as 'making a disclosure in the public interest'

We were told that there were nine people registered at this practice who have a learning disability and that all of these people have an annual review of their health needs. Computerised records reviewed did not demonstrate that these reviews had taken place. We could not find evidence to demonstrate that the practice monitored people in vulnerable circumstances, such as those people with a learning disability to make sure they were safe.

Medicines Management

We discussed medicines management with the practice nurse and health care assistant. There were dedicated secure fridges where vaccines were stored. Records were available to demonstrate that the temperature of vaccination fridges was recorded on a daily basis. This helped to ensure that vaccinations were stored within the correct temperature range and were safe and effective to use. We saw that medication policies were available which had been reviewed on an annual basis.

Systems in place for on-line ordering, reviewing and authorising of repeat prescriptions were robust. Training had been implemented for reception staff regarding repeat prescribing systems. We saw evidence that an audit had taken place for pharmacy requests for repeat prescriptions. We were told and saw that prescriptions were not authorised when the maximum number of repeat prescriptions had been issued. Prescription pads were securely stored.

We discussed a medication error which had been recorded as a significant event. We saw that systems had been improved to try to ensure that this error would not re-occur.

Evidence was available to demonstrate that medication reviews were held on an annual basis for people who were suffering from long term conditions. Computerised records seen showed that the majority of annual medication reviews have been completed as required (91% of patients on four or more medicines had received a medication review and 82% of patients on repeat prescriptions). As part of a contracted local enhanced service (LES) patients were given a medication review within 72 hours of discharge from hospital and appropriate follow up was also completed.

We looked at the medication available for use by staff in an emergency situation. We saw that this medication was stored appropriately and was easily accessible to staff when required. However there were no checks in place to ensure medicines were available and kept within expiry dates. We were told that staff were replacing items when they were used but that there was no documented system to demonstrate that appropriate checks had been made. Medication available on the day of inspection was within its expiry date.

We saw that the practice had an automatic external defibrillator. This machine is used to try and re-start a person's heart, for example, if they have suffered a cardiac arrest. We were told that a check was made on a daily basis to ensure this equipment was in working order. However there were no records to demonstrate this.

We were told that there was no emergency oxygen on the premises. We asked the practice manager if a risk assessment had been completed. This would help to demonstrate the level of risk to patients if emergency oxygen is not available. We were told that there was no risk assessment available.

During our inspection of the premises we noted that urine analysis test strips were out of date in two treatment rooms.

The electronic prescription service (EPS) was in use at this practice. EPS enables doctors and practice nurses to send prescriptions electronically to a pharmacy of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. The system also identifies if a patient does not request an expected repeat prescription or requests a prescription earlier than should be necessary. This is particularly important for those people who may have mental health issues

Cleanliness & Infection Control

We discussed infection prevention and control with the practice manager, practice nurse and health care assistant. We looked at policies and audits undertaken. We inspected doctors' surgeries and treatment rooms. Facilities were in a

good state of repair, suitable flooring had been laid and chairs seen were easily cleanable. We saw that sharps bins were available. These were used to safely dispose of used "sharps" such as needles. Sharps bins should be labelled with the date of first use. We saw that this had not always been completed. Staff were unable to confirm the date that this sharps bin was opened. NICE guidance states that sharps bins should be disposed of every three months. During our inspection the health care assistant completed the label on the sharps box.

We looked at the infection control policy and the hand decontamination policy. We saw that these were reviewed on an annual basis. The infection control policy did not record a named "infection control lead". This should be the person who would provide guidance regarding infection control to staff working at the practice as needed. Staff spoken with were not aware who was the infection control lead and it appeared that this role had not been allocated to a member of staff.

During our inspection of the premises we noted that all areas appeared to be visibly clean and hygienic. The practice manager confirmed that an external company undertook cleaning duties at the practice. We were shown a copy of a cleaning plan developed by the practice manager and cleaning specification used by the cleaning company. This detailed the frequency of tasks to be undertaken. During our discussions with the practice manager we were told that when issues had been identified regarding cleanliness, discussions were held with the cleaning company. There was no evidence of a documentary system in place to monitor the cleanliness of the practice.

Training records seen did not demonstrate that all staff had undertaken infection control training. The practice manager told us that infection control, E-learning had been organised for two weeks following this inspection.

We asked to see evidence of a legionella risk assessment and any subsequent legionella testing carried out at the practice. We were told that the building was not owned by the provider. The building owner had contracted an external company to undertake this testing. The practice manager confirmed that hot and cold water checks were undertaken on a regular basis. There were no records on the premises to demonstrate that a legionella risk assessment and water testing had been completed.

Equipment

We spoke with staff and looked at equipment. The practice nurse told us that all equipment needed to effectively complete her role was available and in good working order. We were told that the CCG had arranged for portable appliance testing (PAT) to be undertaken. We saw that not all equipment had a sticker in place to demonstrate that it had been tested. We were informed that some equipment which had been purchased by the doctor such as kettles, toasters had not been tested by the company who completed the testing. The practice manager had been informed that it was their responsibility to ensure that this equipment was tested. There was no documentary evidence on the premises to demonstrate that all equipment had been tested as required.

We discussed the calibration of equipment such as blood pressure monitors, scales and electrical couches. We were told that equipment had not been calibrated recently and this was due to be completed. We could not find any documentary evidence to demonstrate when equipment had been calibrated previously. The practice manager told us that the company had not put stickers on equipment previously and had not left paperwork.

We were told that fire fighting equipment such as fire alarms and emergency lighting was tested on a regular basis but records were not available on the premises to demonstrate this.

Staffing & Recruitment

There had been some changes to staffing at the practice recently and difficulties in recruiting staff. Systems were in place to ensure that busy periods and times of sickness and annual leave were covered by existing staff. Staff confirmed that they were required to book annual leave in advance to enable staff cover to be arranged.

The practice manager told us and staff confirmed that staff wellbeing was monitored. We were told that the practice manager had an "open door policy" and staff were able to speak with her at any time. The practice manager discussed some recent staffing issues and the additional support provided.

Requires improvement

Are services safe?

Systems in place for the recruitment and training of staff were not robust. We saw a staff recruitment policy which was brief and did not clearly describe the pre-employment information and checks required before staff gained employment at the practice.

We looked at the staff recruitment files for five members of staff. We saw that not all information as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was available. Information such as; a full employment history, together with a satisfactory written explanation of any gaps in employment, satisfactory information about any physical or mental health conditions which were relevant to the person's ability to work and satisfactory evidence of conduct in previous employment were not available in all personnel files seen. The practice manager confirmed that some of the recently employed staff had been known to the practice and therefore some of the recruitment checks had not been fully completed.

Some staff files contained documentary evidence to demonstrate that newly appointed staff had undertaken induction training at the practice, although other files seen did not contain this information. One staff member spoken with confirmed that they had undertaken induction training.

We saw evidence that clinical staff registration with their professional body was up to date.

Locum GPs were used occasionally at this practice to cover times of annual leave, training or sickness. We asked to see documentary evidence of checks undertaken on locum doctors who worked at the practice. The practice had a service level agreement with a locum agency. We were told that there was no documentation available to demonstrate that locums used at the practice were appropriately checked and registered. This information had not been forwarded to the practice by the locum agency. Checks should be available such as a disclosure and barring service (DBS) check, evidence of general medical council (GMC) registration and evidence that the locum was registered on the performers list. Medical practitioners may not perform any primary medical services, unless they are a general medical practitioner and their name is included in a medical performers list. The practice therefore had no documentary evidence to demonstrate that the use of locums was safe.

Monitoring Safety & Responding to Risk

We were not shown any evidence to demonstrate that appropriate risk assessments took place regarding the premises. The property was not owned by the provider and we were told that all risk assessments were completed by the building owners. A fire and legionella risk assessment had apparently been completed; however there was no documentation available to confirm this. We were not shown any documentary or other evidence to demonstrate that any other health and safety risk assessments had been completed. The practice could not demonstrate that appropriate checks and risk assessments had been completed to ensure that the premises were fit for use.

Records seen did not demonstrate that staff had undertaken fire training. We were told that fire training had not been provided recently and staff training was overdue.

Arrangements to deal with emergencies and major incidents

We saw that a disaster recovery plan was in place. This document listed the action to take due to loss of access to the premises, systems, equipment or staff. We saw that this document had been reviewed in September 2014. However, we noted that the plan required more information, for example the plan stated that if the premises were not accessible, an alternative practice premises would be used. There was no information regarding the premises that would be used. We spoke with the practice manager about this and she confirmed that they had considered other premises but had no formal agreement in place. We also saw that the plan recorded issues that may arise, such as flooding, loss of IT systems but did not record in detail the action that staff should take to ensure that the practice continued to provide an effective service to patients until issues had been addressed.

In the event of an emergency we saw that medication and some appropriate equipment was available, for example emergency drugs and a defibrillator. There was no emergency oxygen on site and no risk assessment to demonstrate the level of risk for not having this available. There was no documentary evidence to demonstrate that checks were taking place to ensure the equipment was in working order and medication was in date and available.

Requires improvement

Are services safe?

Emergency call systems were in place to enable staff to alert colleagues should an emergency situation arise such as an emergency medical situation or if staff were faced with abusive or threatening behaviour by a patient.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

A GP we spoke with was aware of the need to stay updated regarding changes to guidelines. We discussed best practice and the National Institute for Health and Clinical Evidence (NICE) guidance with the doctor. We were told how clinicians accessed and kept up to date with national guidelines.

Systems were in place to review the care needs of those patients with complex needs or those in vulnerable circumstances. Palliative care meetings took place on a three monthly basis with a multidisciplinary team. The practice carried out annual health checks for people with serious mental health illness. Records showed that 91% of patients in this category were having their blood pressure monitored and 88% of patients have undertaken discussions regarding alcohol intake. The GP we spoke with had attended training regarding osteoporosis assessment to identify the risk of fragility fracture. This assessment would be used to identify patients who may be at an increased risk of bone fracture due to osteoporosis and who would benefit from preventative treatment.

Patients had their needs assessed and care planned in accordance with best practice.

Management, monitoring and improving outcomes for people

The Practice had a system in place for completing clinical audit cycles. For example we saw a pharmacy led audit which was a Clinical Commissioning Group (CCG) initiative regarding the usage of two types of medication. Other completed audits undertaken included the frequency of thyroid function test completion at nursing homes and the use of food supplements. A dietician was involved in the care of all people who were involved in the food supplement audit.

We were told about various monitoring and screening systems in place to improve patient outcomes. Cognitive impairment screening was used at the practice to identify those patients who may be suffering from a dementia illness. The six item cognitive impairment test was used as part of this process. Blood monitoring was also undertaken for disease modifying anti-rheumatic drugs (DMARDs). This included arranging for tests to be completed when patients were discharged from hospital. Test results could be reviewed on the practice's computer system. DMARDs are a group of medicines that are used to ease the symptoms of rheumatoid arthritis (RA) and reduce the damaging effect of the disease on the joints. Because these medicines were taken for a long time patients needed to have regular blood tests to see if the DMARDs had produced any side-effects.

The practice carried out reviews as part of the Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. Overall the practice was meeting its performance targets for QOF. We were told about the recently introduced system of recalling patients for annual reviews of their long term health conditions.

We saw the minutes of meetings which demonstrated that multi-disciplinary meetings were held on a three monthly basis to manage and monitor the care delivery, treatment and support of patients receiving palliative care. Community services involved in the care delivery of these patients attended these meetings.

Effective staffing

Training records seen in staff files did not all demonstrate that staff had undertaken training such as infection control, safeguarding or fire training. Some staff files seen did not record any evidence of training undertaken. We spoke with the practice nurse who felt that the doctor was very supportive and tried to ensure that all training requested was available to staff. We were told about future training booked for the practice nurse to undertake which helped to ensure that she was working to current standards and guidelines. A member of administration staff said that they had not undertaken any training recently but felt that their training needs had been met.

We discussed continuing professional development (CPD) with the practice nurse. Clinical staff were responsible for ensuring their CPD was up to date and these staff held their CPD records. There was no system in place for the practice manager to monitor to ensure staff were up to date with CPD.

The practice manager confirmed and we saw records to demonstrate that learning needs were identified during appraisal meetings. However, one appraisal record that we reviewed identified that the member of staff required

training in medical terminology. We spoke with this staff member who said that they had not as yet undertaken this training (appraisal dated 2012). The practice manager told us and the doctor confirmed that in-house medical terminology training had been provided.

We were told that staff appraisals had not taken place during 2013. One member of staff spoken with who had worked at the practice for approximately 18 months had not received an appraisal since they commenced their employment.

Working with colleagues and other services

The practice took some action to work with other service providers in order to manage and monitor the care delivery, treatment and support of palliative care patients. Three monthly palliative care meetings were held with practice staff and community service staff involved in the care delivery of the identified patients. We were shown a computerised system which identified those patients on the palliative care register. We saw that records were not up to date and were not all fully completed.

We did not see any evidence to demonstrate that the practice worked with other colleagues regarding vulnerable patients, or those who had been identified as at risk of abuse.

The practice had a policy for communicating with out of hours services and other providers. Systems were in place to ensure that special notes were sent to out of hours providers so that important information was shared.

Blood results, X ray results, letters from hospital for example outpatients and discharge summaries were received electronically. The information was seen and actioned by the GP on the day they were received. The GP reviewing the documentation and results would instruct administration staff of the action required, for example they would record that the patient should be contacted and seen as this was clinically necessary.

Information Sharing

The practice had systems in place to provide staff with the information needed to offer effective care. An electronic patient record, EMIS, was used by all staff to coordinate, document and manage patients' care. All staff were trained on the system. Alerts were available within the system to ensure staff were aware of key information relevant to each patient.

This software enabled scanned paper communications, such as those from hospital to be cascaded to the appropriate clinician and saved in the system for future reference.

Electronic systems were also in place for making referrals, and the practice made 303 referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

Consent to care and treatment

The practice had a policy regarding consent which had been reviewed annually. All minor surgical procedures and a patient's verbal consent were documented in the electronic patient notes. Systems were in place to ensure consent for any treatment was received. Mental capacity was discussed and staff said that if they felt a patient did not have mental capacity they would not continue with the examination or procedure. The GP told us that he had undertaken formal training regarding the mental capacity act and we saw a copy of his training certificate to confirm this. We were told that no other staff had undertaken this training

Health Promotion & Prevention

We noted that there was no health promotion information on display in the practice waiting area. We were told that the practice no longer had a leaflet board. There was limited information on display to signpost people to health promotion services and the practice no longer had a website which could signpost people to other services.

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse or health care assistant. The GP was informed of all health concerns detected and these were followed-up in a timely manner.

We were told that NHS health checks were a method used to identify those patients at risk of developing long some term conditions. However, upon further discussion it was identified that staffing issues at the practice had resulted in a low number of health checks being undertaken. We were told that only 9% of the practice population aged 40 – 74 had received this health check up until December 2013.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice nurse was responsible for undertaking any relevant assessments of patients with long term conditions but there were no specific clinics held, such as diabetes, or asthma at the practice. The practice nurse told us that people preferred not to be constrained by clinic times and were able to book a time which suited them.

The practice's performance for cervical smear uptake was 87% which was better than others in the CCG. There was a policy to offer reminders for patients who did not attend for cervical smears. There was a named nurse responsible for following-up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spent some time in the reception area and waiting room. Staff at reception were polite and friendly towards patients and were attentive and helpful with any requests for assistance. We saw that on one occasion staff assisted a patient to walk to the car park. Patients completed CQC comment cards to provide us with feedback on the practice. We received 47 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful and respectful of people's illnesses. Generally people commented that all staff were caring and considerate. They said staff treated them with dignity and respect. Four comments were less positive and concerns raised related to the ability to get an appointment with the GP. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice. Patients appeared to be at ease and had a good relationship with reception staff.

We could not see any evidence that a hearing loop was provided, reception staff were unaware if a hearing loop was available and there was no signage to inform patients that a hearing loop was present. A hearing loop is a special type of sound system for use by people with hearing aids. The doctor was able to show us where the hearing loop was located. Making patients aware of the availability of a hearing loop may assist with maintaining their privacy, confidentiality and dignity whilst speaking with reception staff.

We spoke with reception staff about the facilities available to speak with a patient who wished to speak with staff in private. We were told that they would be able to use the practice manager's office or there was often a consulting room available.

Discussions with staff evidenced that they maintained dignity and compassion when conducting examinations. We discussed an example of this and were told that an appointment was changed for a male patient who only wished to see a male GP. Staff were aware of the telephone translation service available, we were told that some staff were able to communicate with patients in alternative languages and the doctor was able to use basic sign language for those patients who were hard of hearing. A register was available to record those patients who required the use of the translation/interpretation service.

We saw that some end of life planning took place. The doctor held discussions with the patient and their family members as appropriate to discuss end of life care. Do not attempt resuscitation forms were completed and signed if this was the patient's wish.

We were told that the practice was currently accepting new NHS patients and would accept people who may be homeless,

Reception staff told us they would like to attend conflict resolution training due to a recent incident in which a patient climbed over the reception counter and was aggressive towards staff.

Care planning and involvement in decisions about care and treatment

Patients were satisfied that they were involved in decisions about their care and treatment and this was confirmed in comment cards received. Comment cards also stated that the doctor listened, explained options and gave advice if needed. Patients spoken with on the day of our inspection told us that health issues were discussed with them and treatment choices explained. They told us they felt listened to and sufficient time was allocated during consultations.

Patient/carer support to cope emotionally with care and treatment

We were told that a bereavement card was sent to families who had suffered bereavement. An appointment to see the doctor was offered if needed and the telephone number of bereavement care service was given. The doctor was able to describe an instance of bereavement support that was provided to a family after the unexpected death of a family member.

Reception staff were reminded to ask patients if they were also a carer, new patient registration forms also captured this information. The practice's computer system alerted GPs if a patient was also a carer.

Staff spoken with had a caring attitude and all discussed the need to provide high quality care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice did not have an active patient participation group (PPG). PPGs are a group of patients who meet on a regular basis and can help the practice to engage with a cross-section of the practice population and obtain patient views. The practice manager told us that they had found it difficult getting members to attend the PPG meetings and the group had disbanded. Posters had been put on display and people had been asked if they wished to join the PPG but this had not been successful.

There was an effective triage system in place and all patients needing to be seen urgently were offered same-day appointments or a home visit. Telephone consultations were also available.

The practice had implemented the gold standards framework for end of life care. They had a palliative care register and had three monthly multidisciplinary meetings to discuss patient and their families care and support needs. Reception staff were aware of the number of patients on the palliative register. However, computer records had not been updated with current information. Staff were aware that computer records required updating.

Tackling inequity and promoting equality

During our inspection we discussed the practice's website with the practice manager. We were told that the website was out of date and was no longer used. The practice manager was considering developing a new website.

Various systems were in place to aid working patients to access the service. Appointments were available from 8.30am to 6.30pm on Tuesday, Wednesday and Friday. The surgery closed early at 12.30pm on a Thursday and extended opening hours were provided on a Monday evening until 7.30pm which was particularly useful to patients with work commitments. Patients were able to obtain telephone advice from the GP. Text reminders were sent to remind people of their appointments and to give test results which fell within the "normal" range.

We saw that there was limited information in the waiting area signposting patients to support services available.

The practice had access to online and telephone translation services and the GP was able to speak spoke Hindi and Bengali.

Access to the service

We were told that there were six appointment slots saved each day for people who may need to be seen urgently. These appointments could be booked by telephoning at either 8.30am or 3.30pm. We were told that children would always be seen on the day that the urgent appointment was requested and this was confirmed by patients that we spoke with. Telephone consultations could also be requested and the GP set time aside at the end of each clinic to make these phone calls.

We were told by the doctor that both registered and non-registered patients would be fitted in for urgent appointments if they attended the practice. However, reception staff did not confirm this and said that once the urgent appointment slots were full patients would be asked to attend an alternative service such as a walk in centre.

An on-line booking system was available for patients to book appointments at the practice.

The practice also operated the "choose and book" system for booking appointments with specialists. Choose and Book is a service that lets patients choose the hospital or clinic and book their first appointment. Choose and Book shows the doctor which hospitals or clinics are available to provide the appropriate treatment for the medical condition.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns and there was a designated responsible person who handled all complaints in the practice. Details of how to make a complaint were included in the practice leaflet. We looked at the complaints policy and saw that

Good

Are services responsive to people's needs?

(for example, to feedback?)

this gave the contact details of other organisations who would investigate complaints if the complainant was not happy with the outcome of the investigation completed by the doctor.

The practice had a system in place for recording and responding to complaints, copies of complaints were made available to us to demonstrate this. We looked at the details of the complaints received within the last twelve months, we spoke with the practice manager and administration staff about complaints processes. We looked around the waiting area and noted that the complaints policy was not on display. There were no details of services available that could assist people to make a complaint, such as advocacy services. We were told that people who wished to make a complaint would have to request a copy of the complaint form and policy from reception staff.

Staff we spoke with confirmed that complaints were discussed during monthly staff meetings and actions were agreed and learning outcomes discussed. We saw that the complaints systems had been amended as the result of a complaint received.

None of the patients spoken with had ever needed to make a complaint about the practice.

Are services well-led?

Requires improvement

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

Our findings

Vision and Strategy

We discussed the vision of the service with the practice manager. We were told that there was no formally documented vision statement or strategy for future working. The practice manager was able to discuss future changes such as increased staff numbers and future working arrangements but confirmed that this was not recorded.

Staff spoken with had a caring attitude and all discussed the need to provide high quality care.

Governance Arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We were told that the doctor, practice manager and nurse met on a two weekly basis to look at QOF achievements to date in order to maintain or improve outcomes.

The practice did not hold governance meetings. The practice manager told us that governance arrangements, issues and updates were discussed at the practice meetings. The minutes of the practice meetings that we looked at did not demonstrate this.

The practice had completed the information governance (IG) toolkit for 2013/14 and achieved a 97% compliance rate. The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards.

The Practice had a system in place for completing clinical audit cycles. For example we saw a pharmacy led audit which was a Clinical Commissioning Group (CCG) initiative regarding the usage of two medications. Other completed audits undertaken included the frequency of thyroid function test completion at nursing homes and regarding the use of food supplements. A dietician was involved in the care of all people who were involved in the food supplement audit.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Policies and procedures we looked at had been reviewed annually and were up to date.

Leadership, openness and transparency

Not all staff spoken with were aware of who had been nominated for lead roles, for example regarding infection control or safeguarding. However, staff said that they were a small team who worked well together and they would speak with the doctor or practice manager to obtain any advice or raise issues. Staff described management as supportive and said that there was a culture of openness at the practice. We were told that staff could speak with the doctor at any time to discuss issues or concerns.

The practice manager was responsible for human resource policies and procedures. We discussed how staff performance was monitored and were given examples of when poor performance had been identified and action taken, following appropriate disciplinary procedures.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through a survey undertaken in 2013 by the patient participation group. A synopsis of the results was available on-line. We saw that some action had been taken to address issues raised. Another method of obtaining patient feedback was via a comments box which was located in the reception area. However, we noted that there was no paper available for patients to record any comments or suggestions. We were told that patients could ask reception staff for a comments form if required, but patients did not use this facility.

The practice does not have an active patient participation group (PPG). The practice manager confirmed that PPG meetings had previously been held but people had not been available to attend meetings and therefore the PPG had disbanded. We saw that there was a poster on display in the reception area encouraging patients to join the PPG. The practice manager discussed ways in which they had tried to persuade people to become members of the PPG but confirmed that they had not been successful.

The practice did not have a formally documented system for gathering feedback from staff, for example a staff survey.

Are services well-led?

Requires improvement

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

However, staff told us that they would speak with the practice manager or GP if they had any concerns. We saw the minutes of a practice staff meeting in which it was recorded that staff had raised concerns and been requested to speak with the doctor outside of the meeting to discuss their concerns in depth. Staff confirmed that the practice manager was approachable and helpful and could be contacted at any time for help.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training but we could not find documentary evidence of this in all staff files we reviewed. We looked at five staff files and saw that personal development plans were included although it was not clear that these had been addressed on all occasions. We could not find evidence to demonstrate that all staff had undertaken an induction upon employment at the practice.

We saw documentary evidence to demonstrate that complaints systems had been amended following a recommendation from the Public Health Service Ombudsman. However, there was no information on display to inform patients how to make a complaint.

We saw that details of incidents were recorded; however the learning outcomes and action to be taken were not routinely recorded. We were told that incidents were discussed at practice meetings; however the details of the discussions were not recorded in the meeting minutes. There was limited evidence to demonstrate that learning from incidents had taken place. The practice had not completed a review of significant events to identify trends.

We discussed the systems in place to monitor quality and make improvements to services provided. We were told that a waiting time audit had been completed and as a consequence an extra doctor's session was introduced.

Quality assurance systems in place were not robust. For example there was no system for the checking of medicine or equipment to be used in an emergency. The practice did not have evidence to demonstrate that appropriate checks had been undertaken on locum GPs used at the practice and had no evidence that they had undertaken pre-employment checks on staff they had employed. We were not shown evidence to demonstrate that risk assessments had been completed on the premises, for example a legionella risk assessment. Systems were not in place to ensure that staff had undertaken training appropriate to their role.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: We found that the provider did not operate effective recruitment procedures to ensure that employees are of good character and did not ensure that the information specified in Schedule 3 was available in relation to each person employed. Regulation 19(1)(a)(b)(2)(a)(3)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: We found that the provider had not ensured that staff were appropriately supported by receiving training and appraisal to enable them to undertake their responsibilities safely and to an appropriate standard. Regulation 18(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Maternity and midwifery services

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the Regulation was not being met

We found that the provider had not protected people against the risks of inappropriate or unsafe care and treatment by means of effective operation of systems designed to enable the registered person to -

regularly assess and monitor the quality of services provided in the carrying on the regulated activity

identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from them carrying on of the regulated activity.

Regulation 17(1)(2)(a)(b)