Dr Lalta Sachdeva

Quality Report

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Lalta Sachdeva on 5 May 2016.

The practice was rated as inadequate and was placed in special measures. Practices placed in special measures are inspected again within six months of publication of the last inspection report. If insufficient improvements have been made and a rating of inadequate remains for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service.

Additionally, a breach of the legal requirements was found because systems and processes had not been established and operated effectively. As a result, the provider was not assessing, monitoring and improving the quality and safety of the services provided and mitigating the risks related to the health, safety and welfare of service users and others. Therefore, a Warning Notice was served in relation to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good Governance. because;

Following the comprehensive inspection, we discussed with the practice what they would do to meet the legal requirements in relation to the breach and how they would comply with the legal requirements, as set out in the Warning Notice.

We undertook this announced focused inspection on the 12 October 2016, to check that the practice had followed their plan and to confirm that they now met the legal requirements. The practice was not rated as a consequence of this inspection, as the practice is in special measures. It will be inspected again, with a view to assessing the practice's rating when the timescale for being placed into special measures has passed.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by using the link for Dr Lalta Sachdeva on our website at:

http://www.cqc.org.uk/location/1-500922994/reports

The areas where the provider must make improvements are:

- Ensure that the systems and processes to assess, monitor and improve the quality and safety of the servicesthat minutes comprehensively record the

Summary of findings

discussion held, that the process for routinely monitoring how the practice sought consent is effective and that risk assessments, audits and random sample checks of patient records are monitored and reviewed in order to assess how effective they were.

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?

At our previous comprehensive inspection on the 5 May 2016 the practice was rated as inadequate for providing safe services. There were no formal processes to ensure that risks to patients and staff safety were being monitored and managed. For example, staff did not formally report incidents, near misses and concerns. Lessons learned were not formally communicated and so safety was not always improved and there were no systems to routinely check that the landlord had carried out up to date fire risk assessments and fire drills and testing of electrical equipment, medicine management was not always safe, and emergency equipment and medicine checks were not routinely recorded.

At our focused inspection on the 12 October 2016, the practice provided records and information to demonstrate that the requirements of the Warning Notice had been met. This included:

- Formal systems to underpin how significant events, incidents and concerns were monitored, reported and recorded.
- Information about safety was being used to promote learning and improvement. However, there were two systems available to staff to formally record incidents, one hand written and one computerised.
- There were systems to enable a thorough analysis of significant events to be carried out.

There was documented evidence to show that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. Records showed that lessons were shared and action was taken to improve safety in the practice. For example, safety records, incident reports, minutes of meetings and a Duty of Candour Recording book.

Are services effective?

At our previous comprehensive inspection on the 5 May 2016 the practice was rated as inadequate for providing effective services. Care and treatment was not delivered in line with recognised professional standards and guidelines and there was no evidence to support quality improvement activity. There were concerns in relation to how the practice monitored its performance and there was no evidence that the practice was comparing its performance to others; either locally or nationally. The data that was available showed that patient outcomes were below average for the locality.

Summary of findings

At our focused inspection on the 12 October 2016, the practice provided records and information to demonstrate that the requirements of the Warning Notice had been met. This included processes and systems to help ensure that:

- There were formal arrangements for monitoring safety, using information from audits, risk assessments and routine checks.
- Fire safety equipment had been appropriately checked.

Systems to routinely check that there were up to date fire risk assessments, records of regular fire drills, testing of electrical equipment to ensure the equipment was safe to use and working properly and legionella testing, had been conducted and relevant certification had been obtained.

Are services well-led?

At our previous comprehensive inspection on the 5 May 2016 the practice was rated as inadequate for providing well-led services. The registered person did not assess, monitor and improve the quality and safety of the services provided. The practice had not established an overarching governance framework which supported the delivery of good quality care. Additionally, the practice did not have formal systems to underpin how significant events, incidents and concerns should be monitored, reported and recorded and information about safety was not used to promote learning and improvement.

At our focused inspection on the 12 October 2016, the practice provided records and information to demonstrate that the requirements of the Warning Notice had been met. This included processes and systems to help ensure that:

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- Patients' records and repeat prescriptions were stored securely at all times.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to continually monitor and improve quality and identify risk.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure that the systems and processes to assess, monitor and improve the quality and safety of the servicesthat minutes comprehensively record the discussion held, that the process for routinely monitoring how the practice sought consent is effective and that risk assessments, audits and random sample checks of patient records are monitored and reviewed in order to assess how effective they were.

Dr Lalta Sachdeva

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Dr Lalta Sachdeva

Dr Lalta Sachdeva (also known as Abbey Court Medical Centre) delivers services from purpose built premises in Tunbridge Wells, Kent. There are approximately 4,388 patients on the practice list. The

Dr Lalta Sachdeva (also known as Abbey Court Medical Centre) delivers services from purpose built premises in Tunbridge Wells, Kent. There are approximately 4,388 patients on the practice list. The practice is similar across the board to the national averages for each population group. For example, 6.2% of patients are aged 0 -12 months compared to the CCG average of 6% and the national average of 5.9% and 20.4% are aged under 18 years compared to the CCG average of 21.8% and the national average of 20.7%. Scores were similar for patients aged 65, 75 and 85 years and over**.** The practice is in one of the least deprived areas of Kent.

The practice holds a Personal Medical Service contract and is led by one GP (female). The GP is supported by a salaried GP (male), a practice nurse (female) and a healthcare assistant (female), a practice manager and a team of administration and reception staff. A range of services and clinics are offered by the practice including asthma and diabetes.

The practice is open from 8am to 6.30pm. Morning appointments are from 8.30am to 11.00am and afternoon appointments are from 3.30pm to 6.00pm. There is an early morning clinic every Tuesday from 7am to 8.30am and an early evening clinic every Wednesday from 6.00pm to 7.30pm.

An out of hours service is provided by Integrated Care 24, outside of the practice's normal opening hours. There is information available to patients on how to access this at the practice, in the practice information leaflet and on the website.

Services are delivered from:

Abbey Court Medical Centre, 3rd Floor Abbey Court, 7-15 St Johns Road, Tunbridge Wells, Kent TN4 9TF

Why we carried out this inspection

We undertook an announced focused inspection of Dr Lalta Sachdeva on 12 October 2016. This inspection was carried out to check that improvements had been made to meet the legal requirements imposed upon the practice, following our comprehensive inspection on 5th May 2016.

We inspected the practice against three of the five questions we ask about services: is the service safe, is the service effective and is the service well-led. This is because the practice was not meeting one of the legal requirements in relation to these questions.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed information sent to us by the practice that told us how the breach identified during the comprehensive inspection had been addressed. We carried out an announced visit on 12 October 2016.

During our visit we:

- Spoke with a range of staff including the principal GP, the practice nurse, the practice manager and three members of the administration team.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed information, documents and records kept at the practice.

Are services safe?

Our findings

Formal systems to underpin how significant events, incidents and concerns were monitored, reported and recorded had been established.

Information about safety was being used to promote learning and improvement. However, there were two systems available to staff to formally record incidents, one written and one computerised. We found that as a consequence of the formats available, a significant event had been recorded by a GP but had not been shared on the computer system, in order for it to be shared with the staff team.

There were systems to enable a thorough analysis of significant events to be carried out. Minutes of meetings showed that significant events were discussed at staff meetings.

There was documented evidence to show that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. Records showed that lessons were shared and action was taken to improve safety in the practice. For example, safety records, incident reports, minutes of meetings and a Duty of Candour Recording book.

Overview of safety systems and processes

The practice had implemented further systems, processes and practices to keep patients in relation to the management of medicines:

- There was a system to check the fridge temperatures on the daily basis. Records confirmed this. Emergency medicines were routinely checked on a monthly basis. There were records to evidence that such checks had been made.

Monitoring risks to patients

Risks to patients were assessed and managed.

- There were formal arrangements for monitoring safety, using information from audits, risk assessments and routine checks, and these had been implemented and carried out. Fire safety equipment was recorded as checked in May 2016. The building was owned by a landlord who was responsible for premises safety; systems to routinely check that there were up to date fire risk assessments, records of regular fire drills, testing of electrical equipment to ensure the equipment was safe to use and working properly and legionella testing, had been conducted by the landlord and certification had been obtained. The provider had implemented a system for routinely liaising with the landlord.

Arrangements to deal with emergencies and major incidents

The provider had improved the arrangements to respond to emergencies and major incidents.

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Routine checks of these were carried out by practice staff on a monthly basis. Records viewed confirmed this.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The provider had improved the system and processes for assessing needs and delivering care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- A system for NICE guidance and alerts to be routinely discussed and monitored had been established and implemented. Meeting minutes showed these were discussed with the staff team and how they were used to inform the delivery of care and treatment to meet patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice).

- There was evidence of quality improvement as outcomes for patients were monitored through risk assessments, audits and random sample checks of patient records.
- Two clinical audits had been commenced. One had recently been commenced and one was three months into the audit with a date of December for review.An on-going programme of clinical audits used to monitor quality and systems in order to identify where action should be taken had been implemented.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Systems and processes had been improved to ensure the process for seeking consent was routinely monitored through patient records audits. However, due to read code (the way in which consent is recorded with a code in patients' records) and formatting issues, entries were not always easy to access.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear vision of the future of the practice. The newly appointed salaried GP was aware of the vision, strategy and objectives of the practice. The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. Following the implementation of regular formal team meetings, which were minuted, the practice was able to evidence that the vision of the practice was being discussed with staff.

Governance arrangements

The provider had implemented an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and helped ensure that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff we spoke with confirmed this.
- Systems and processes had been established and were being operated effectively to help enable the practice to assess, monitor and improve the quality and safety of the services provided.
- Practice specific policies and procedures had been improved. Records showed that staff had signed a form to show they had read and understood them. Minutes of staff meetings also showed that policies and procedures had been discussed at these meetings. Staff told us the practice held regular team meetings and that they were involved in discussions about how to run and develop the practice, and the GPs and management team encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- A programme of clinical and internal audit had been established in order to monitor quality and to make improvements. For example, monitoring referrals and appointment availability. However, these required further time to be embedded.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Risk reporting systems had been enhanced and staff had received in-house training in what constituted a significant event, and in how to report and record them. Records showed that processes were being followed by staff, in line with the policy.
- Whilst risk assessments, audits and random sample checks of patient records had been established, for example, through audits, checks for consent and premise risk assessments, these required further time to be embedded.
- Improvements had been made to ensure that the facilities the practice had for the storage of patients' confidential information, were being used appropriately. Additionally, completed repeat prescriptions ready for collection were now stored securely when the premises were closed overnight.

Leadership and culture

The principal GP was striving to provide a safe, effective, caring and well led oversight of the practice, in order to ensure high quality care. Improvements had been made to address the issues with governance and leadership identified at the previous comprehensive inspection.

Staff told us that :

- Practice meetings were now held formally. Records showed that minutes of such meetings were recorded.
- They felt valued and supported and were being kept informed about developments within the practice.
- They were aware of significant events, complaints and some safety issues and they were encouraged to raise concerns or identify areas for improvement to the services provided. There was documentary evidence that reflected that significant events, safety alerts and updates to guidance, such as NICE guidelines were being acted upon and discussed with staff in a timely manner.
- We saw minutes of monthly practice meetings held. These minutes were available for staff to read at any time. For example, we saw entries for significant events recorded as 'significant events – discussed'.

The provider was aware of the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There were systems to ensure compliance with the Duty of Candour,

Are services well-led?

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

which included support training for all staff on communicating with patients about notifiable safety incidents. The provider had implemented a system to ensure that when things went wrong with care and treatment and gave affected people reasonable support, truthful information and a verbal and written apology.

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

The practice had gathered feedback from their patients via the use of the Friends and Family Test, a comments/ suggestions box and a feedback book in the reception area for patients to use,

The practice had introduced a virtual patient participation group (PPG) and names of volunteer members had been obtained. We saw posters in the waiting room promoting the importance of a PPG and the practice was trying to recruit more new volunteers before arranging a meeting to discuss the terms and reference of the group.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and felt involved and engaged to improve how the practice was run. Systems and formal processes had been implemented in order to ensure these were monitored, recorded and responded to.

Continuous improvement

There was evidence to suggest that there was an ethos of continuous learning and improvement within the practice. Staff told us that the new systems and processes gave them a sense of purpose and made their tasks meaningful rather than simply functional.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not always 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). In that: • The systems to underpin how significant events were monitored, reported and recorded, had not been fully established, in order to ensure the two systems in use were working effectively. • Records of meetings that had taken place were not always comprehensive in detail. • The process for routinely monitoring how the practice sought consent was not always effective, as coding and formatting issues on patients' records had not been addressed. • Risk assessments, audits and random sample checks of patient records, required further time to be embedded. In order for the practice to monitor and review how effective they were.