Dr Patrick Gonsalves

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Dr Patrick Gonsalves' practice on 21 October 2015. This inspection was to follow up warning notices we issued after a comprehensive inspection on 23 February 2015, which resulted in an overall rating of inadequate.

We found the provider to be in breach of the following regulations:

- Regulation 17: Good governance
- Regulation 19: Fit and proper persons employed

As this was a follow up inspection we looked at specific areas to see if improvements had been made following our previous inspection. A third party provider was working with the practice with a view to forming a partnership. It was evident that the improvements to meet the warning notice requirements had taken place since their involvement with the practice.

Summary of findings

As this inspection was to focus on the warning notice the original rating remains. This will be reviewed at the comprehensive inspection.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Staff understood their responsibilities for the management of patient safety alerts; information was recorded, monitored, appropriately reviewed and addressed.
- The practice had a number of newly developed policies and procedures to govern activity and staff had access to these via the practice computer system. The practice had implemented governance meetings, where issues were discussed. Two meetings had been held prior to our inspection.
- The Infection Prevention and Control (IPC) lead had been identified; they had not received training to undertake this role. The practice had completed one infection control audit and developed an action plan.
- All staff were up to date with basic life support training, but not infection prevention and control (IPC), chaperone training and other training relevant to their roles.
- Recruitment checks for staff had been completed and where gaps were identified these were being addressed.
- Staff felt supported by management. The practice had started to proactively seek feedback from staff and patients.
- A fire risk assessment, fire alarm tests and fire drills had been completed.
- The practice had not undertaken regular staff appraisals

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

The provider should:

Ensure suitable arrangements are in place to support staff appropriately to deliver care and treatment safely by receiving suitable training and appraisal.

Ensure that policies and procedures are maintained and up to date.

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?

The practice is rated as inadequate for providing safe services. The staff files reviewed contained evidence that appropriate recruitment checks had been completed. For example, proof of identification, qualifications and DBS checks. Where there was no proof of a DBS check, for administration staff evidence was available to indicate that an application for DBS had been sent.

Are services well-led?

The practice is rated as inadequate for being well - led. Recent improvements that had been made occurred as a result of third party intervention, the practice was unable to demonstrate that the recent improvements were embedded and sustainable.

Staff felt supported by the new management structure. The practice had a number of policies and procedures to govern activity and had implemented governance meetings, where issues were discussed. There were systems in place to monitor and improve quality and identify risk. The practice had started to proactively seek feedback from staff and patients. Staff had received inductions and attended staff meetings and events. Staff were not up to date with all training the practice identified as mandatory or relevant to their roles. Staff appraisals had not been completed.

Dr Patrick Gonsalves

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 advisor, and a second CQC inspector.

Background to Dr Patrick Gonsalves

The practice operates from a single location at 432 Kingstanding Road, Kingstanding, Birmingham. The services provided include: minor surgery, a range of clinics for long term conditions, health promotion and screening, family planning and midwifery. The practice holds a General Medical Services (GMS) contract to deliver essential primary care services to approximately 1500 patients. The patient population registered at the practice are similar to the national average with a slightly higher number of patients between the ages of 40-50. Data from Public Health England shows that the practice is located in an area where income deprivation is higher than the England average. The practice has one male GP (provider) who works three and half days. We were told that two regular locum GPs (one male and one female) also work at the practice at other times.

The practice is open Monday to Friday 8am to 6.30pm. Extended opening hours are available on Monday evenings until 7.30pm. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours service (Primecare) and there was information on the practice answer phone advising patients of how to contact the out of hours (OOH) service outside of practice opening hours

Why we carried out this inspection

The focused inspection was carried out under Section 60 of the Health and Social Care Act 2008 to follow up from a previous comprehensive inspection at Dr Patrick Gonsalves practice in February 2015. At this previous inspection we identified breaches of Regulation 17 (Good governance) and Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008. We took enforcement action against Dr Patrick Gonsalves by issuing two warning notices to inform him that services must improve.

This inspection was to assess that the provider had met the requirements of the two warning notices, issued under the Health and Social Care Act 2008. This inspection will not result in a change of overall rating.

How we carried out this inspection

We carried out the focused inspection on 21 October 2015. During our inspection we spoke to one locum GP, two members of administration staff, the practice nurse and three senior members of staff from the third party provider, one of which was the Medical Director. We reviewed three locum GP records, three staff records and other supporting information. We did this to check that improvements had been made following our previous inspection.

Are services safe?

Our findings

Staffing and recruitment

We looked at the files of three GP locums; two of the files contained all the appropriate information. One file did not have all the necessary documents on file, a check list from the locum agency confirmed that the locum agency had undertaken these checks. The practice was communicating with the agency so that they could provide copies of the appropriate documents.

The staff files of three permanent staff members were reviewed and they all contained evidence that appropriate recruitment checks had been completed and all staff had received training in basic life support. For example, proof of identification, qualifications and DBS checks. Where there was no proof of a DBS check, for administration, staff evidence was available to indicate that an application for DBS had been sent. The practice had started re-arranging the structure and content of the staff files, so that information was easily located.

A system was in pace to ensure sufficient GP cover was available, this included the use of locums supported by the Medical Director when necessary.

Are services well-led?

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

Our findings

Governance arrangements

In January 2015 Kingstanding Surgery was prioritised by Birmingham Cross city Clinical Commissioning Group (CCG) for support under the Peer Support Team Programme. Support was offered in January 2015 and accepted in February 2015. The Peer Support GP provided a clear view that the practice was not able to resolve issues, given the longstanding nature of some issues together with the absence of key staff members in the practice. The practice requested further interim support from the CCG on 10 September 2015. Support was provided by third party provider assigned by the CCG on 28 September 2015, to work with the practice. At the time of our inspection on 21 October 2015, the GP and practice manager were not available.

We issued a warning notice to the provider following our previous inspection requiring them to put systems in place to ensure good governance by 29 August 2015.

The third party provider, over the last three weeks, had implemented changes to meet the requirement of the warning notice. The practice had secured some improvements for example, policies and procedures had been introduced, significant events had been discussed and lessons learned, an infection prevention and control audit had been completed, a fire risk assessment had been undertaken and staff training addressed . However sufficient time had not passed for the practice to be able to demonstrate that these were embedded and would be sustained. A full comprehensive inspection will take place within six months of the publication of our previous report.

We saw that policies had been reviewed, for example, Infection Prevention and control (IPC) in June 2105, safety alert management October in 2015 and incident management in May 2015 and these were available to staff on the shared drive on any computer within the practice. Key policies, for example incident management were available as printed copies behind the reception area. These new polices had been emailed to all staff and minutes of the practice meeting 20 October 2015, confirmed this. Staff were aware of their responsibilities in reporting incidents.

The practice had reviewed previously reported significant events and made sure that all information fields were completed. Analysis of two of these significant events was undertaken at the practice meeting held on 20 October 2015. The minutes of the meeting evidenced the discussion and actions taken to mitigate the risk of re-occurrence. For example the action taken to ensure that laboratory results are reviewed in a timely manner, locum doctors and the Medical Director providing support to the practice had access to review all results.

The locum GP on duty during the inspection confirmed that they had completed six sessions at the practice in the last six weeks and they had not encountered any significant events during this time, but they were aware of the incident management procedure.

Previously it was unclear who was responsible for managing patient safety alerts. A new safety alert procedure was introduced October 2015. The procedure and recent alerts were discussed at the practice meetings held on 9 and 20 October 2015. Minutes of the practice meeting held on 20 October 2015 confirmed that the safety alert policy had been emailed and received by all staff and specific recent alerts were listed as agenda items.

At our previous inspection there was no evidence that a fire safety risk assessment had been completed. A fire risk assessment had been competed on 8 October 2015. The action plan identified four actions, two of which were completed immediately and the other two for completion by the end October 2015. Staff confirmed that they were aware of the location of the new fire information and a fire evacuation took place on 19 October 2015.

Reception staff acted as chaperones when the nurse was not available, one member of staff informed us that they had acted as a chaperone but had not received training. However they did understand their responsibilities when acting as a chaperone, including where to stand to be able to observe the examination. The practice had recently reviewed all staff files to ensure that appropriate checks through the Disclosure and Barring Service (DBS) had been completed.

We spoke with three members of staff, they all told us that they felt well supported by the current management structure and knew who to go to with any concerns. The practice planned to hold fortnightly practice meetings, we looked at the minutes from 9 and 20 October 2015 and found that quality and risks had been discussed.

Are services well-led?

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

The practice had implemented processes to review patient satisfaction, Friends and Family comment cards were available, the third party provider had requested access to the NHS Choices web site in order to respond to patient comments. Risk assessments had been carried out on all areas identified in the warning notices. Further action was required to ensure the practice could demonstrate that they met the fundamental standards set out in the Health and Social Care Act 2014. Twenty one actions were recorded, fourteen had been completed and seven had completion dates for 30 October 2015 and 6 November 2015. Governance issues were discussed at practice meetings, we looked at minutes that confirmed this.

We reviewed staff training records which confirmed that all staff were up to date with basic life support training, but not infection prevention and control (IPC), chaperone training and other training relevant to their roles. The practice nurse had recently been appointed as the lead for IPC but had not received training to fulfil this duty. The third party provider had identified further training needs and staff had been provided with access to an e-learning training module, a rota for protected training time was planned.

We looked at three staff files and saw that regular appraisals had not taken place. The third party provider were aware that appraisals were required and had planned a schedule for appraisals.

The infection prevention and control Procedure (IPC) had been developed in June 2015 and all staff were aware of it. Although the practice nurse was the lead for IPC they had not received any training on infection control.

An IPC audit was completed on 19 October 2015. Seventeen actions were identified, two of which had been completed and the remainder of the actions to be completed by the end of November 2015, where appropriate a plan had been put in place to mitigate the risk.

A Legionella (a bacterium which can contaminate water systems in buildings) risk assessment had been completed by the practice, this was not dated, it stated that there was no actual or potential risk to staff and quoted references from the Health and Safety Executive (HSE) website. The third party provider had arranged for a risk assessment to be carried out by an external contractor, this was scheduled for 6 November 2015.

Management lead through learning and improvement

Staff told us that they had all been given access to the e-learning system and a rota was being developed to allow them protected time to undertake training, at the time of the inspection this had not been implemented. The practice had completed reviews of significant events and other incidents and these had been shared with staff at practice meetings.