Dr Satya Kacker

Quality Report

Broom Valley Medical Centre
102-104 Broom Valley Road
Rotherham
South Yorkshire
S60 2QY
Tel: 01709 365244
Website:

Date of inspection visit: 2 June 2015
Date of publication: 20/08/2015

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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Satya Kacker's practice on 2 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all the population groups. It required improvement for providing safe services.

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 and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment and legionella risk assessment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

Summary of findings

The practice, in partnership with a local school, held an open afternoon once a year for school children to experience the day to day running of the surgery. They used this event to promote healthy living and to provide aspiration and inspiration for pupils to consider future employment in the health sector.

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

Importantly the provider should:

- Ensure audits of practice are relevant to the patient population and improve patient outcomes.
- Ensure a legionella risk assessment is completed.
- Ensure actions from incidents are completed in a timely manner.
- Review the provision of oxygen on the premises.
- Ensure all staff have an annual appraisal and the opportunity to meet with their line manager to discuss objectives, action planning and progress.
- Review access to interpreting services for those patients who need it.

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 providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough enough and lessons learned were communicated widely to support improvement. We noted not all actions identified were completed in a timely manner. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, a legionella risk assessment had not been undertaken. The necessary employment checks had not been obtained before the most recent member of staff started their employment.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff completed appraisal forms but did not meet with their line manager to discuss them. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice comparably to others for aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments

Summary of findings

available the same day. The practice had good facilities and was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. 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. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, attended staff meetings and events.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed outcomes for patients were good for conditions commonly found in 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Those over 75 were offered a six monthly review to check their health and medication needs were being met.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The GP led in chronic disease management supported by a member of the administrative team to arrange patient appointments and referrals to other services. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured six monthly review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this, Appointments were available for children under the age of five on the same day and outside of school hours. The premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice held an open afternoon once a year for local school children to attend. The practice used this event to promote healthy living and to provide aspiration and inspiration for pupils to consider future employment in the health sector.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Of people experiencing poor mental health, 84% had received an annual physical health check. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) whilst they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. A mental health practitioner held a clinic at the practice once a week.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive which related to the chairs in the reception area and the patient toilets.

We also spoke with eight patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient told us they had made a complaint about a prescription and was waiting to speak to the practice manager. Patients also told us they found practice to be clean and tidy.

Patients told us their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015 (25.6% response rate). The GP scores were slightly lower than the CCG average with 86% of practice respondents saying the GP was good at listening to them and 84% saying the GP gave them enough time.

Reception scores were above average as 95% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure audits of practice are relevant to the patient population and improve patient outcomes.
- Ensure a legionella risk assessment is completed.
- Ensure actions from incidents are completed in a timely manner.
- Review the provision of oxygen on the premises.
- Ensure all staff have an annual appraisal and the opportunity to meet with their line manager to discuss objectives, action planning and progress.
- Review access to interpretation services for those patients who need it.

Outstanding practice

The practice, in partnership with a local school, held an open afternoon once a year for school children to experience the day to day running of the surgery. They used this event to promote healthy living and to provide aspiration and inspiration for pupils to consider future employment in the health sector.

Dr Satya Kacker

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a second inspector, a GP specialist advisor and a practice nurse specialist advisor.

Background to Dr Satya Kacker

Dr Satya Kacker's practice, or Broom Valley Medical Centre as it is known locally, is located in the Broom Valley area of Rotherham. The practice is part of Rotherham Clinical Commissioning Group (CCG) and is responsible for providing services for 1,845 patients under the general medical services (GMS) contract with NHS England.

The practice catchment area is classed as within the group of the third most deprived areas in England. The age profile of the practice population differs slightly to other GP practices in the Rotherham CCG area. It has a larger number of male patients aged from birth to nine years old and 35 to 39 years old and a higher number of females from five to 14 years old registered at the practice.

The practice has one female GP who works six sessions a week and male locum GP who works four sessions per week. They are supported by one senior receptionist, three receptionists and one practice manager. A health trainer and a mental health practitioner hold clinics at the practice once a week to support patients.

The practice is open from 8am to 6.30pm Monday to Friday. Extended opening is available on Monday evenings until 8pm.

Dr Satya Kacker is registered to provide: Maternity and midwifery services; Family planning; Diagnostic and screening procedures; Treatment of disease, disorder or injury from Broom Valley Medical Centre, 1 Barber Road, Sheffield, S10 1EA.

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 registered 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.

Please note when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

How we carried out this inspection

Before visiting, we reviewed information we hold about the practice and asked Rotherham CCG and NHS England to share what they knew. We carried out an announced visit on 2 June 2015. During our visit we spoke with the GP, the practice manager, three members of the administrative team and the health trainer. We also spoke with eight patients who used the service and reviewed 35 comment cards. We observed how people were being cared for and talked with carers and/or family members and reviewed the

Detailed findings

personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff at the practice had reviewed the procedure for accepting specimens from patients to ensure it complied with infection prevention and control principles.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Review of significant events was a standing item on the practice meeting agenda. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They were also reported to the CCG. They showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We noted not all of the actions had been completed for two of the incidents. They both related to incidents which occurred in 2013 where the actions identified were to review a policy and a procedure. We did not see evidence confirming these had been reviewed.

We noted where patients had been affected by something which had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts which were relevant to the care they were responsible for. They also told us alerts were discussed at the monthly practice meeting to ensure all staff were aware of any which were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and adults whose circumstances may make them vulnerable. We looked at training records which showed all staff had received relevant role specific training on safeguarding. We asked members of medical and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The GP was the lead for safeguarding children and adults whose circumstances may make them vulnerable. They had been trained to level three in both child and adult safeguarding. They could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice electronic record system. This included information to make staff aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans.

Staff at the practice told us how they identified and followed up children, young people and families living in disadvantaged circumstances. This included looked after children, children of substance misusing parents and young carers. Staff would attend child protection case conferences and serious case reviews where appropriate. Reports were sent to the GP if staff were unable to attend. We noted there was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Requires improvement

Are services safe?

Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GP's attention, who then worked with other health and social care professionals.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All reception staff would act as a chaperone. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. We noted temperatures were being documented using the incorrect decimal value. For example, 0.3 degrees centigrade was written as opposed to 3 degrees centigrade. This was reported to the practice manager.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. We noted the glucogel, taken if a person has a low blood sugar, had expired. All other expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice's prescribing rates were comparable to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health reviews were completed for long term conditions such as diabetes and the latest prescribing guidance was being used.

The prescribing module in the patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence after receiving an alert the GP had reviewed the use of the medicine in question. Where they continued to prescribe it, they outlined and documented the reason why they decided this was necessary.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular checks of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection prevention control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection prevention control.

An infection prevention control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the infection prevention and control policy. Reception staff told us how the safe handling of specimens had been reviewed to ensure it complied with the policy. There was also a procedure for needle stick injury and staff could describe what to do in the event of an injury.

The practice had a lead for infection prevention and control (IPC). All staff received induction training about IPC specific to their role and received annual updates. We saw evidence

the lead had carried out a recent IPC audit in June 2015. The actions were yet to be implemented. For example to safely position sharps containers out of reach from those considered vulnerable.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We noted not all hand soap dispensers were wall mounted and the tiles behind the taps in the patient toilet were cracked. The seating in the reception area was in a poor state of repair and was torn in places. This had all been identified in the infection prevention and control audit and the practice manager told us this would be addressed in the action plan.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). A risk assessment had not been undertaken. The practice manager told us they would contact the landlord to determine the building legionella testing status.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment currently used was tested and maintained regularly. We saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was October 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained some evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, references, registration with the appropriate professional body and the appropriate checks through the DBS. We noted written references were requested but not received for the most recent member of staff recruited. The practice manager told us this would be followed up.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patient need. We saw there was a rota system in place for reception staff to ensure enough staff were on duty. There was also an arrangement in place for members of administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included dealing with emergencies. Staff told us they would also verbally inform the practice manager if they identified any issues or risks. These were then dealt with in a timely manner. We were told any identified risks were discussed at practice meetings.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had carried out a fire risk assessment in 2014 which included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised regular fire drills. Staff told us the fire equipment was tested annually.

The appointments systems in place allowed a responsive approach to risk management. For example, when there were no appointments available for people who requested an urgent appointment on the same day, the GP would be informed and ring the patient back.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. We noted oxygen was not available in the practice. We asked to see a risk assessment as to why the practice did not have this. We were told one had not been completed. An automated external

Requires improvement

Are services safe?

defibrillator, used to attempt to restart a person's heart in an emergency, was available. All members of staff we spoke with knew the location of the other emergency equipment and records confirmed it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included adrenaline (which can be used to treat anaphylaxis); hydrocortisone (for treating asthma or recurrent anaphylaxis). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the emergency medicines we checked were in date and fit for use apart from the glucogel.

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the utility companies if power was lost.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager and GP how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. This was then discussed at practice meetings and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having six monthly health reviews and referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital as needed.

The GP told us they led in specialist clinical areas such as diabetes, heart disease and asthma. They were supported by a member of the administrative team to arrange patient appointments and referral to other services. They told us they were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. We saw after patients were discharged from hospital they were followed up to ensure all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The GP told us clinical audits were often recommended by the CCG which we noted were only relevant to a small proportion of the practice population. We were shown three clinical audits which had been undertaken in the last two years. For example, regarding the prescribing of medicines for gout. Following the audit, the GP carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. The GP maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the quality outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. Dr Satya Kacker's practice was not an outlier for any QOF or other national clinical targets. It achieved 97% of the total QOF target in 2014, which was above the local or national average of 94%. Specific examples to demonstrate this included:

- Performance for diabetic care was better than the national average.
- The percentage of patients with high blood pressure having regular blood pressure checks was better than the national average.
- Performance for mental health care was better than the national average.

Good

Are services effective?

(for example, treatment is effective)

However the dementia diagnosis rate was lower than the local and national average.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice had a palliative care register and held multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and those considered vulnerable. All of these patients were offered six monthly structured health reviews or more frequently as their condition changed. For example, those who had a diagnosis of diabetes, chronic obstructive pulmonary disease (COPD) or heart failure.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes were comparable to other services in the area. For example, prescribing of antibacterial medicines.

Effective staffing

Practice staffing included medical, managerial and administrative staff. The practice had recently recruited a healthcare assistant and was currently advertising for a practice nurse due to a vacancy. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Administration staff told us they completed annual appraisal documentation and sent it to the practice manager. They did not always meet with their manager to discuss their appraisal review. The practice manager told us they had not had an appraisal within the last two years.

Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example a business administration course for administrative staff.

Staff had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties.

We were told where poor performance had been identified appropriate action would be taken following the practice's policy. Managers told us they did not have any recent examples of when the policy had been used.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by the GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries which had not been followed up.

Emergency hospital admission rates for those patients with long term conditions were relatively low at 20% compared to the local average of 25%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end

of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the medical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient was deemed not to have capacity to make a decision. The GP demonstrated a clear understanding of the Gillick competency test. These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, administration of vaccines. The patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted the practice culture was for staff to use their contact with patients to help maintain or improve their mental, physical health and wellbeing. For example, by promoting the work of the health trainer who held a clinic in the practice once a week, to support patients to achieve weight loss goals.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients within two weeks, if they had identified risk factors for disease at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 98% of patients with certain conditions and actively offered smoking cessation clinics with the health trainer to 95% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those who required end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 76%, which was the same as the national average. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer.

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 was higher than the local area for the majority of immunisations where the data was available.

Good

Are services effective?

(for example, treatment is effective)

Practice staff showed us the resources available to patients including those experiencing poor mental health. This included using voluntary sector agencies to promote independent living and patients could be referred to primary care based talking therapies. Annual health reviews were offered to patients with severe mental health issues and the uptake was 86% which was comparable to the average of 86% for the local area. Patients were offered flexible appointment times, avoiding booking appointments at busy times for people who may find this stressful.

The practice, in partnership with a local school, held an open afternoon once a year for school children to experience the day to day running of the surgery. This was during practice learning time and they used this event to promote healthy living and to provide aspiration and inspiration for pupils to consider future employment in the health sector. Staff at the practice provided different activities for the children to experience during their visit including how to take blood pressure and how to prevent heart disease; the dangers of smoking and passive smoking to encourage children not to start smoking and support their parents to stop smoking. They also had the opportunity to act as a GP giving out health advice to their classmates and to work in reception booking pretend patients into appointments on the training area of the patient record system.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in January 2015 completed by 109 patients (26% response rate).

The evidence showed the majority of patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed the practice was comparable to the local and national average. For example:

- 86% said the GP was good at listening to them compared to the CCG average of 88% and national average of 87%.
- 84% said the GP gave them enough time compared to the CCG average of 87% and national average of 85%.
- 89% said they had confidence and trust in the last GP they saw compared to the CCG and national average of 92%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive which related to the chairs in the reception area and the patient toilets. We also spoke with eight patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient told us they had made a complaint about a prescription and was waiting to speak to the practice manager.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. Additionally, 95% of respondents to the national patient survey said they found the receptionists at the practice helpful compared to the CCG and national average of 86%.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed the majority of patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice comparable to others in the area. For example:

- 79% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 82%.
- 68% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 74%.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us they would ask patients who did not have English or Punjabi as a first language to bring a friend or relative along with them to interpret for them. We noted the practice did not have access to telephone interpreting services for patients whose first language was not Punjabi

or English. Patient's would be asked to bring friend or family member to accompany them into the consultation to interpret for them. A British Sign Language interpreter could be requested for those patients who needed it.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were mostly positive about the emotional support provided by the practice and rated it slightly below the CCG average in this area. For example:

- 77% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 82%.

The patients we spoke with on the day of our inspection and the comment cards we received highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website advised patients how to access a number of support groups and other local services. The information was available in English and Punjabi and staff at the practice told us they were exploring the provision of other literature in different languages to meet the needs of the patient population, particularly those from eastern Europe. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us if family's had experienced bereavement, the GP would contact them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Local Area Team and CCG told us the practice engaged regularly with them and other practices to discuss local needs and service improvements needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We were told how the practice reviewed the appointment length for GPs after it was fed back some sessions did not run to time. A GP's appointment time was increased to 15 minutes to allow clinics to run to time.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, those supported by an advocate or on request. The majority of the practice population were English speaking patients. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been modified to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets. Baby changing facilities were available on request. There was a waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There was a male and female GP in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 8am to 6.30pm Monday to Friday. Appointments were available from 9.30am to 12 noon and various afternoon hours between 1pm to 5.30pm during the weekdays.

Comprehensive information was available to patients about appointments in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the patient record online portal. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long term conditions. Home visits were available to those patients who needed and the GP visited one local care home on a specific day each week to see patients.

A weekly clinic was held for patients with long term conditions. Patients were reviewed every six months or sooner if needed. Annual health reviews were also performed which included a review of the patients' medications.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 82% were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 91% described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.
- 47% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.
- 88% said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 71%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, a patient told us they had telephoned the practice in the morning for an appointment for their child and had been seen by the GP two hours later.

Appointments were available outside of school hours for children and young people and the premises were suitable for children and young people. Children under the age of five were offered an appointment on the same day. The GP told us they worked closely with sexual health clinics and the local chemist who dispensed free contraceptives as necessary.

Patients could book online appointments and request repeat prescriptions via the online patient record system portal. Patients we spoke with who used the system reported it was easy to use.

A health trainer held a clinic in the practice once a week to support patients in making life style choices to improve their health. A mental health practitioner also held a clinic at the practice once a week. Reception staff told us they would avoid booking appointments at busy times for people who may find it stressful.

We were told those patients who had wounds and required dressing changes could visit the local walk in centre to have them done or a visit by the district nurse could be arranged. Patients requiring blood tests could have their blood taken at the walk in centre or at the hospital.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system. The practice leaflet included details of how to make a complaint and there was also a poster in the waiting room. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the patients we spoke with had made a complaint recently relating to a prescription and was waiting for further contact from the practice manager.

The practice manager told us they had only received two verbal complaints in the last 12 months. The practice manager told us there were no themes to these. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

(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 mission statement, staff spoke enthusiastically about working there and they told us they felt valued and supported. Staff told us their role was to provide the best care to patients. We asked if the practice had developed an overall vision or practice values staff had taken time out to contribute to and staff told us this happened informally at the practice meetings where all staff contributed.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in files kept within the practice. We looked at 10 of these policies and procedures and all staff had completed a cover sheet to confirm they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually. We noted the recruitment policy referred to the Criminal Record Bureau. We fed back to the practice manager this had been replaced by the Disclosure and Barring Service. All other policies were up to date.

We spoke with five members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. The full time GP was the lead for safeguarding and staff could tell us this.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing just below local and national standards. The practice achieved 97% of the available QOF points for the year 2013-14 compared to the CCG and national average of 94%. We saw QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

We were not shown an on going programme of clinical audits; although we were shown evidence clinical audits were taking place.

The practice had arrangements for identifying, recording and managing risks. Whilst we found evidence some aspects were good, we identified a number of areas where improvements were needed. For example, the practice had not made sure there were proper arrangements in place for assessing the risk of legionella and ensuring recruitment checks were completed. The individual risks were regularly discussed at team meetings and incident forms updated in a timely way.

The practice held monthly practice meetings where governance issues were discussed.

Leadership, openness and transparency

We saw from minutes, team meetings were held monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies. For example, disciplinary procedures and the induction policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. They told us the meetings had temporarily become less frequent as the members had other commitments. The group were working with the practice manager to recruit more patients to the PPG. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The practice had also gathered feedback from staff at staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and

Are services well-led?

Good

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

mentoring. We looked at two staff files which included a personal development plan. Staff told us the practice was very supportive of training and they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.