

Dr B. Bekas

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.

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at the practice on 24 May 2016. This inspection was carried out to check that improvements had been made following our comprehensive inspection, which was carried out on 12 November 2015. At that time we identified areas which required improvement within the safe and effective domains. These issues were:

- The practice did not have robust systems in place for reporting, investigating or learning from significant events. The practice had only reported one event within the previous 12 months and there were arrangements for reviewing accidents, incidents or near misses to help improve safety.
- The practice procedures for recruiting new staff were not followed. Checks including proof of identity, evidence of skills and experience were not carried out.
- Relevant staff did not have a Disclosure and Barring Services (DBS) check and there was no risk assessment in place to determine that these checks were not required.

- The practice did not have oxygen or an automated external defibrillator (AED) for use in the event of a medical emergency. There was no risk assessment in place to support this decision and to identify and mitigate risks to patients.
- Clinical and diagnostic equipment had not been calibrated and some pieces of equipment such as the weight scales were damaged.

We issued a requirement notice under Regulation 12 of the Health and Social Care Act 2014 in relation to improvements that were required. The overall rating for the practice was requires improvement.

Additionally we found that some improvements were needed within the effective domain. The practice performance for outcomes for patients with diabetes was lower than other practices locally and nationally. The practice performance for patient uptake of cervical screening was also low and the practice had not been able to demonstrate what actions they had taken to address these issues.

We asked the practice to provide an action plan detailing how the areas for improvement were to be addressed. The practice submitted an action plan on 12 January 2016.

Summary of findings

When we visited the practice on 24 May 2016 we reviewed the improvements made by the practice within the safe domain. We found:

- Significant events were reported and four had been reported since our last inspection. However these had not been fully reviewed and there were recorded actions to help minimise their recurrence.
- The practice manager told us that DBS checks had been carried out for all staff. They showed us the completed checks for a GP, two receptionists, one administrative member of staff and the practice nurse.
- One nurse recently employed at the practice had not been through a thorough recruitment process. This included a lack of recruitment checks such as proof of identity and confirmation that they were registered with their professional body.
- We found one blood pressure monitor in the GP's room which had not been calibrated since 2014. We were not assured that other equipment in use at the practice had been calibrated.
- The practice did not have an Automated External Defibrillator and there was no risk assessment in place to support this decision.

- Written complaints were investigated and responded to appropriately. However verbal complaints and concerns arising from these were not followed up.

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

Importantly the provider must:

- Ensure that there are appropriate systems in place to monitor and improve the quality and safety of the services provided. This relates to systems for investigating and learning from when things go wrong and using this learning to reduce risks to patients.
- Ensure that appropriate checks are carried out for all newly appointed staff to determine that they are of good character and have suitable skills, knowledge and experience; and are registered with the relevant professional body if required.

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?

- There were limited procedures in place for acting on and learning from safety events such as accidents, incidents or near misses.
- The systems for calibrating diagnostic equipment were not robust or carried out consistently. The practice manager could not evidence that all equipment was calibrated and we found some equipment which had not been calibrated since 2014.
- Cleaning materials were not stored securely or safely.
- Staff were not recruited robustly and all of the required checks including proof of identification, Disclosure and Barring Services (DBS) checks and registration with appropriate professional bodies (where relevant) were not carried out.

Requires improvement



Are services effective?

The practice had made the required improvements which we identified when we inspected in November 2015. There were arrangements to follow up on patients who failed to attend appointments for reviews of long term conditions and health screening.

- The practice performance for outcomes for patients with diabetes was similar to or better than other GP practices locally and nationally.

Good



Are services well-led?

The practice did not have sufficient governance arrangements to monitor and improve the quality and safety of services provided.

- The provider had failed to make the required improvements identified following the comprehensive inspection.
- There were limited systems in place for monitoring the service and ensuring that equipment required was available and working properly.
- There were insufficient systems in place for using learning from significant events and complaints to make improvements.

Requires improvement



Summary of findings

Areas for improvement

Action the service **MUST** take to improve

- Ensure that there are appropriate systems in place to monitor and improve the quality and safety of the services provided. This relates to systems for investigating and learning from when things go wrong and using this learning to reduce risks to

patients. It also relates to systems for ensuring that there is sufficient equipment to treat patients and that this equipment is regularly checked to ensure that it is working properly.

- Ensure that appropriate checks are carried out for all newly appointed staff to determine that they are of good character and have suitable skills, knowledge and experience; and are registered with the relevant professional body if required.

Dr B. Bekas

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The inspection also included a second CQC inspector.

Why we carried out this inspection

We carried out a focused follow up inspection to review the improvements made in relation to the areas of concern that we identified when we carried out a comprehensive inspection on 15 November 2015.

Are services safe?

Our findings

Safe track record and learning

The practice did not have robust systems in place for reporting, investigating or learning from significant events. We saw that four incidents had been reported since November 2015. These included coding errors, patient test results filed before being reviewed by the GP and incorrect patient x-ray requests. We saw that these had not been recorded in detail. Learning from these incidents had not been recorded and there was no review of the incidents to ensure that learning had been imbedded into practice to help minimise recurrences.

Overview of safety systems and processes

- There were some procedures in place for checking and calibrating diagnostic equipment to ensure it was working properly. The practice manager showed us a certificate that demonstrated that some equipment had been calibrated in November 2015. However the practice manager told us that a GP held some equipment in their GPs bag used when away from the practice and they could not be assured that this had been checked or calibrated. We found a blood pressure monitor in the GPs room, which had not been calibrated since 2014.

- The practice had a risk assessment in place in relation to the control of substances hazardous to health (COSHH) such as cleaning materials. However we found that combustible materials were stored, unlocked in an area where electrical meters were stored. The practice manager told us that they had been unaware that these products were stored there and indicated that they had moved them from a room elsewhere in the practice where they were usually stored.
- The practice had a policy for employing new staff. However this was not followed consistently. The practice manager gave us a list of staff who they told us were employed to work at the practice. However when reviewing complaints made about the practice we found that the practice had recently employed a nurse practitioner. We requested the recruitment file for this member of staff and were advised by the practice manager that there was no file or recruitment record available for them and that no recruitment checks had been carried out.

Arrangements to deal with emergencies and major incidents

The practice did not have an automated external defibrillator (AED) and there was no risk or other assessment had been carried out to support this decision. Following our inspection the practice informed us that an AED had been purchased.

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Data from 2014/15 showed;

Performance for the treatment and management of diabetes was as follows:

- The percentage of patients with diabetes whose blood sugar levels were managed within acceptable limits was 92% compared to the national average of 86%

- The percentage of patients with diabetes whose blood pressure readings were within acceptable limits was 81% compared to the national average of 71%
- The percentage of patients with diabetes whose blood cholesterol level was within acceptable limits was to the same as the national average of 71%

The practice exception reporting for each of these clinical outcomes was lower than the national averages. Exception reporting is a process whereby practices can exempt patients from QOF in instances such as where despite recalls patients fail to attend reviews or where treatments may be unsuitable for some patients. This avoids GP practices being financially penalised where they have been unable to meet the targets a set by QOF.

These checks help to ensure that patients' diabetes is well managed and that conditions associated with diabetes such as heart disease are identified and minimised where possible.

Are services well-led?

Requires improvement 

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

Our findings

Governance arrangements

The practice did not have an overarching governance framework to support improvements in the delivery of good quality care:

- The practice had not fully implemented the improvements identified during the previous inspection and appropriate measures had not been implemented to identify and address risks to patients
- There were insufficient systems in place to ensure that equipment required for the treatment of patients was checked to ensure that it worked properly.
- There was a lack of systems in place for assessing risks associated with the storage of equipment.
- There were insufficient systems in place for monitoring staff recruitment to ensure that all of the appropriate checks to keep people safe had been carried out.
- There were insufficient systems for sharing and acting on learning from significant events and complaints to improve outcomes for patients.

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 Family planning services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Appropriate checks were not made in respect of staff who were working at the practice. Nursing staff were working at the practice without any records maintained in respect of checks including proof of identity, registration with the relevant professional body, employment references or Disclosure and Barring Services (DBS) disclosure. The practice manager told us that these checks had not been undertaken. Regulation 19 (1) (2)
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were ineffective systems and processes in place to monitor, assess and improve the quality and safety of services provided. The provider had failed to ensure that the concerns identified when we last inspected the service had been addressed. For example; Learning from incidents such as significant events or near misses were not shared or used to help minimise such incidents happening. Incidents such as coding errors / misfiled records were not reviewed to help minimise their recurrence. In addition we found: There were insufficient systems in place to ensure that equipment required for the treatment of patients was checked to ensure that it worked properly.

This section is primarily information for the provider

Requirement notices

There was a lack of systems in place for assessing risks associated with the storage of equipment.

Regulation 17 (1) (2)