Dr Jagtar Chaggar

Quality Report

St Paul's Surgery
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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	Good
Are services safe?	Good
Are services effective?	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 Jagtar Chaggar on 8 December 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the September 2016 inspection can be found by selecting the 'all reports' link for Dr Kanjana Paramanathan on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 4 October 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 8 October 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as good.

- During our previous inspection the practice reviews and investigations of incidents or significant events were not thorough enough and lessons learned were not communicated widely to support improvement. At this inspection the practice had reviewed its significant event protocol, developed a more effective process and introduced a learning and analysis element to the significant event investigation template.
- Patient Group Directions (PGD) were signed by a manager and were up to date at this inspection.
- When we inspected the practice in December 2016 we saw procedures for prescribing medicines which required regular monitoring were not implemented consistently for all patients' prescribed high risk medicines. At this inspection we saw that an effective system had been implemented.
- There were appropriate emergency medicines available in the practice.
- The practice had addressed areas of high exception reporting for long term disease management (QOF).
- Audits we looked at referenced quality standards and care pathways. The findings identified improvements in several areas of the referral process. Audits were detailed and had identified areas for improvement which they were acting on.

Summary of findings

- Staff files looked at demonstrated that appraisals had taken place for all staff within the last 12 months.
- Reviews of some care plans demonstrated reference to guidance and the GP we spoke with was able to demonstrate competency in accessing care plans on the system.
- Examples of referral letters we looked at were appropriate in formation. Most GPs used a template on the system for referral letters which they then used to make the referral.
- During our previous inspection we saw that there was no hearing loop in the practice. The practice had considered the installation of a hearing loop and had developed alternative arrangement s to support patients with a hearing impairment in the interim until they moved to new premises
- The practice had reviewed its management structure and had developed a clear organisational chart detailing line management responsibilities and roles.
- When we inspected the practice in December 2016 we saw locum GPs did not appear to have engagement in areas such as QOF performance and the management of long term conditions. They were not routinely involved in evidence based guidelines discussions and there was a risk they may therefore not be aware of valuable clinical information. At this inspection we saw evidence that sessional GPs had taken over responsibility in clinical areas such as for diabetes and mental health. Records of meetings we looked at demonstrated their attendance where guidance was discussed.

The areas of practice where the provider should make improvements are:

- Consider effective ways to ensure patients are made aware of the benefits of health screening programmes.

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?

Good

At our previous inspection, we rated the practice as requires improvement for providing safe services. Records did not clearly evidence that learning from incidents had taken place and that action points had been addressed. Reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Patient Group Directions (PGD) were not always signed and authorised appropriately. Procedures for prescribing medicines which require regular monitoring were not implemented consistently for all patients' prescribed high risk medicines.

We saw evidence that the practice had improved when we undertook a follow up inspection on 4 October 2017. For example:

- The practice had reviewed its significant event protocol and had introduced a learning and analysis element to the significant event investigation template. The practice had also introduced quarterly significant event audit meetings to discuss learning and trends.
- We saw that all Patient Group Directions (PGDs) were signed by a manager and were up to date.
- The practice had reviewed its process for managing patients on high risk medicines. There was a record of all patients on high risk medicines and a designated staff member took on the responsibility of reviewing these patients to ensure effective management. There were alerts on the patient record system and the practice had developed a pathology recall system which added an extra layer of safety which was also reviewed monthly.
- We saw appropriate emergency medicines were available in the practice. The practice had purchased adrenaline that was suitable to administer to adults, children and infants. The practice had a system to ensure all emergency medicines were up to date and appropriately stored.

Are services effective?

Good

At our previous inspection, we rated the practice as requires improvement for providing effective services. Data from the Quality and Outcomes Framework (QOF) showed most outcomes were comparable with or above the national average. However the practice had no plans to address and improve the high exception

Summary of findings

reporting in respect of the management of patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD). Clinical audits did not demonstrate quality improvement. The system for care planning was not effective and a GP was not able to access these on the clinical system on the day of our visit. There was no clinical oversight of referral letters to secondary care services like hospitals. This included patients referred under the two week wait.

We saw evidence that the practice had improved when we undertook a follow up inspection on 4 October 2017. For example:

- The practices Chronic Obstructive Pulmonary Disease (COPD) register showed 55 patients of whom 11 (20%) were excluded so far. The practice was aware of these patients and records we looked at showed that they were appropriately excluded.
- We saw one audit on the (gastrointestinal) referral process which referenced quality standards and care pathways. The findings identified improvements in several areas of the referral process. The practice had also carried out an audit on the use of laxatives in adults. We saw that both audits were detailed and had identified areas for improvement.
- We looked at six staff files and saw that appraisals had taken place for all within the last 12 months.
- Care plans we sampled demonstrated that reference to guidance and the GP we spoke with was able to demonstrate competency in accessing care plans on the system. Clinical notes we looked at showed the care plans were appropriate.
- We looked at examples of referral letters and they contained relevant information. Most GPs used a template on the system for referral letters which they then used to make the referral.

Are services well-led?

Good

At our previous inspection, we rated the practice as requires improvement for providing well-led services. Some staff told us that there was no clear leadership structure and that the roles and responsibilities of the management team were not always clear. There was an overarching governance framework; however clinical audits were not driving improvements in patient care. Locum GPs were not routinely involved in evidence based guidelines discussions and there was a risk they may therefore not be aware of valuable clinical information.

We saw evidence that the practice had improved when we undertook a follow up inspection on 4 October 2017. For example:

Summary of findings

- The practice had reviewed it management structure and had developed a clear organisational chart and had shared this with staff. The organisational chart detailed line management responsibilities and roles. Staff were aware of the line management structure.
- Audits we looked at referenced quality standards, they were detailed and had identified areas for improvement. We saw the findings were discussed at the clinical meeting.
- The practice had reviewed its significant event protocol and developed a more effective process.
- The practice was able to demonstrate understanding of the performance of the practice across all areas. The practice was addressing the high exception reporting for COPD and cervical cytology.
- Locum GPs had taken over responsibility in clinical areas such as for diabetes and mental health. Records of meetings we looked at demonstrated their attendance to the meetings where issues such as safeguarding, medicines and medicine alerts, significant events and long term conditions were discussed.

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
The provider had resolved concerns for providing Safe, effective and well-led care identified at our inspection on 8 December 2016 which applied to everyone using this practice, including this population group. As a result, the population group has been rated as good.

Good

People with long term conditions
The provider had resolved concerns for providing Safe, effective and well-led care identified at our inspection on 8 December 2016 which applied to everyone using this practice, including this population group. As a result, the population group has been rated as good.

Good

Families, children and young people
The provider had resolved concerns for providing Safe, effective and well-led care identified at our inspection on 8 December 2016 which applied to everyone using this practice, including this population group. As a result, the population group has been rated as good.

Good

Working age people (including those recently retired and students)
The provider had resolved concerns for providing Safe, effective and well-led care identified at our inspection on 8 December 2016 which applied to everyone using this practice, including this population group. As a result, the population group has been rated as good.

Good

People whose circumstances may make them vulnerable
The provider had resolved concerns for providing Safe, effective and well-led care identified at our inspection on 8 December 2016 which applied to everyone using this practice, including this population group. As a result, the population group has been rated as good.

Good

People experiencing poor mental health (including people with dementia)
The provider had resolved concerns for providing Safe, effective and well-led care identified at our inspection on 8 December 2016 which applied to everyone using this practice, including this population group. As a result, the population group has been rated as good.

Good

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Consider effective ways to ensure patients are made aware of the benefits of health screening programmes.

Dr Jagtar Chaggar

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC Lead Inspector. The team also included a GP specialist advisor.

Background to Dr Jagtar Chaggar

The practice is situated in Smethwick, West Midlands. The surgery operates out of a two-storey building and clinical services are delivered on both floors. The facilities are generally accessible for patients with a disability. There is no lift to the first floor, although there are arrangements in place for patients with mobility difficulties to be reviewed in the ground floor consulting rooms. There is limited on-site parking but patients are able to park on the streets around the practice.

The staffing team consists of one principal male GP and a male salaried GP. There are two part-time female regular locum GPs and a part-time nurse practitioner. The management team consist of a business manager, practice manager and an assistant practice manager.

The practice is planning to move into purpose-built premises and expected building work is due to commence soon.

There are approximately 8000 patients of various ages registered with the practice. The practice has a General Medical Services (GMS) contract. A GMS contract is a contract between NHS England and general practices for delivering general medical services.

The practice is open between 8am and 6.30pm Mondays to Fridays. Appointments are available from 8.30am to 12.30pm and from 3.30pm to 6pm Mondays, Tuesdays, Wednesdays and Fridays. On Thursdays appointments are available 9pm to 12.30am and 3.30pm to 6pm. When the practice is closed, patients are redirected to their out of hours provider, 'Primecare'.

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Jagtar Chaggar on 8 December 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the inspection on December 2016 can be found by selecting the 'all reports' link for Dr Jagtar Chaggar on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Dr Jagtar Chaggar on 4 October 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

We carried out a focused inspection of Dr Jagtar Chaggar on 4 October 2017. This involved reviewing evidence that:

During our visit we:

- Spoke with a range of staff including the business manager, practice manager, the lead salaried GP, the secretary and other administration/ reception staff.
- Reviewed an anonymised sample of the personal care or treatment records of patients.

Detailed findings

- Looked at information the practice used to deliver care and treatment plans.

Please note that 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.

Good

Are services safe?

Our findings

At our previous inspection on 8 December 2016, we rated the practice as requires improvement for providing safe services. Although staff understood their responsibilities to raise concerns, and to report incidents and near misses, records did not clearly evidence that learning had taken place and that action points had been addressed. Reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. The Patient Group Directions (PGD) were not always signed and authorised appropriately. Although some risks to patients were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, the procedure for prescribing medicines which required regular monitoring were not implemented consistently for all patients' prescribed high risk medicines.

The practice had made arrangements to address the above areas and could demonstrate improvement when we undertook a follow up inspection on 4 October 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

We saw evidence that the practice had reviewed its significant event protocol and developed a more effective process and introduced a learning and analysis element to the significant event investigation template. The practice had introduced quarterly significant event audit meetings to discuss learning and trends. We saw that the previous meeting held in July 2017 discussed significant events between April and June 2017. In total five incidents were discussed and we saw evidence that the root cause was discussed and the learning was shared. The meeting was attended by all the GPs and management team. Incidents were also discussed at the monthly practice meetings and bi-monthly clinical meetings.

The practice also planned to hold annual meetings to review incidents for the previous 12 months to facilitate recognition of emerging trends. We saw there was a template available with a summary of all incidents to further facilitate this.

Overview of safety systems and processes

We saw that the practice had reviewed its process for managing patients on high risk medicines. The practice had a spreadsheet of all patients on high risk medicines such as Disease-modifying anti-rheumatic drugs (DMARDs). We saw that there were 48 patients on the spreadsheet which was reviewed monthly by a designated staff member. There were alerts on the patient record system and the practice had developed a pathology recall system which added an extra layer of safety as this was also reviewed monthly. If a patient was due a blood test they were contacted via telephone or sent a letter instructing them that their blood test was due. This was done following checks on the hospital GP homepage (if under hospital management). If patients already had the blood test the practice updated its records. We looked at some examples and saw that patients were being managed appropriately.

We were told that the practice did not keep a home visit bag and all emergency medicines were kept in the practice. There were consultation rooms on the ground floor and on the first floor of the practice and there were two emergency medicine kits available (one on the ground floor and one on the first floor). The practice had purchased adrenaline at doses suitable for adults, children and infants. The practice had a system to ensure all emergency medicines were up to date and appropriately stored.

Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw that all PGDs were signed by a manager and were up to date.

Arrangements to deal with emergencies and major incidents

The practice had a defibrillator and oxygen with adult and children's masks available on the premises. We saw that monthly checks had been implemented to ensure emergency equipment was in good working order.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 8 December 2016, we rated the practice as requires improvement for providing effective services.

Data from the Quality and Outcomes Framework (QOF) showed most outcomes were comparable with or above the national average. However the practice had no plan to address and improve the high exception reporting in respect of the management of patients diagnosed with COPD. Clinical audits did not demonstrate quality improvement. The system for care planning was not effective and the lead GP was not able to access these on the clinical system on the day of our visit. There was no clinical oversight of referral letters to secondary care services such as hospitals. This included patients referred under the two week wait.

At this inspection we saw the practice had made arrangements to address the above areas and evidence we looked at confirmed this.

Management, monitoring and improving outcomes for people

When we inspected the practice previously, data we looked at showed the exception reporting rate for those patients with Chronic Obstructive Pulmonary Disease, (COPD), in whom the diagnosis has been confirmed by post bronchodilator spirometry between three months before and 12 months after entering on to the register was 20%, compared to a CCG average of 10% and the national average of 9%.

At this inspection we saw that the practice had a register of patients with COPD and there were 55 patients on the register. We saw that 11 patients (20%) were excluded so far. The practice was aware of these patients and records we looked at showed that they were appropriately excluded.

During our previous inspection we also saw that the practice had carried out two completed audits to demonstrate quality improvement. However, when we reviewed these audits it was unclear what improvements had been made as the audits lacked sufficient detail. At this inspection we saw one audit on the (gastrointestinal) referral process referenced quality standards and care pathways. The practice had also carried out an audit on the use of laxatives in adults. We saw that both audits were detailed and had identified areas for improvement and learning was discussed at clinical meetings.

Effective staffing

We reviewed six staff files which demonstrated that appraisals had taken place within the last 12 months. Learning needs were identified where appropriate.

Coordinating patient care and information sharing

We reviewed a sample of care plans and saw that they reflected guidance. The GP we spoke with was able to demonstrate competency in accessing care plans on the system. Clinical notes we looked at showed that the care plans were up to date and appropriate.

We saw that there was a system to ensure that two week referrals were followed up and if patients did not attend their appointment the secretary arranged for a repeat appointment to see their GP. We looked at examples of letters and they contained appropriate information. We spoke with the staff member who told us that most of the GPs used a template on the system for referral letters which they then used to make the referral. One of the GPs created an electronic task with relevant information for the secretary. If they were unclear the secretary told us that they would seek further clarification from the GP.

During our previous inspection we were informed that the majority of test results were being handled by a GP by remote access whilst outside of the practice. At this inspection we were told that the GP accessed the majority of results remotely. Examples we looked at showed that this was being done safely and effectively. The GP told us that this offered flexibility for them and the patients as they could access results and action those that were urgent in a timely way. This was especially useful on Friday afternoons as results could be actioned before the weekend.

Supporting patients to live healthier lives

During our previous inspection, data we looked at showed that the practices exception reporting rate for cervical screening was 25%, compared to the CCG average of 9% and the national average of 7%.

The practice current achievement for cervical screening was 82% (unpublished and unverified data). The practice

Good

Are services effective?

(for example, treatment is effective)

had a total of 1521 eligible patients on the register of which 270 patients were due a cervical screening test this year and the practice was confident that they would achieve their target.

The practice explained that some patients did not attend appointments for their tests due to cultural reasons and a staff member was assigned the responsibility to ensure all these patients were called for a reminder. Although this improved the practices' achievement for cervical screening, it also increased their exception reporting. The practice explained that this staff member exception reported any patients that refused the test rather than escalating this and seeking written consent. The practice had recognised this and had taken action and expected improvement in the current achievement data. The practice ensured that the nurse spoke with all relevant patients when they refused so that they could advise them on the importance of the test before recording the refusal on the patient record system.

When we inspected the practice in December 2016 we saw attendance at both bowel and breast screening were below the local and national averages. For example:

- 59% of eligible females screened (three year coverage) compared to the local average of 66% and the national average of 72%.
- Eligible patients screen for bowel cancer in the last 30 months was 35% compared to the local average of 45% and the national average of 58%.

Although there was no new data to compare if improvements had taken place, we saw that alerts were in place for screening and letters were sent to patients to remind them to attend appointments. There were posters in reception encouraging patients to attend screening. Leaflets were also available and given to patients explaining the benefits of the screening tests.

The locum GP had attended training at the local hospital with the same consultant who held the DiCE clinic at the practice. The locum GP also had an interest in mental health and had taken on clinical responsibility in that area.

Are services well-led?

Good

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

Our findings

At our previous inspection on 8 December 2016, we rated the practice as requires improvement for providing well-led services.

Some staff told us that there was no clear leadership structure and that the roles and responsibilities of the management team were not always clear. There was an overarching governance framework however clinical audits were not driving improvements in patient care. Not all clinical staff were able to access patient care plans to ensure they were kept up to date and relevant to their health needs. Locum GPs did not appear to have engagement in areas such as QOF performance and the management of long term conditions. They were not routinely involved in evidence based guidelines discussions and there was a risk they may therefore not be aware of valuable clinical information. Also, there was infrequent attendance at practice clinical meetings.

At this follow up inspection it was evident that the practice had taken action following the previous inspection and had developed a proactive approach to identifying and manging risks.

Governance arrangements

The management team roles had been clarified in order to define a clear line management structure. Staff explained that there were three managers and each had different responsibilities. At times this had caused some confusion with staff members. The practice had addressed this with a clear organisational chart in place. The management team now consisted of a business manager whose responsibility included areas such as finance and recruitment; a practice manager whose role was the day to day running of the practice; an assistant manager to help the practice manager and a senior administrator who oversaw reception responsibilities. There was an organisational chart with detailed staff roles and line management responsibilities. We spoke with three staff members who told us that the new management structure had been discussed with them and they were much clearer on the management structure and who to approach if they had any issues.

The practice had reviewed its significant event protocol and developed a more effective process and introduced a learning and analysis element to the significant event investigation template. The practice had also introduced quarterly significant event audit meetings to discuss learning and trends.

When we inspected the practice in December 2016 the practice was unable to demonstrate they had a comprehensive understanding of the performance of the practice across all areas, for example, how they were addressing the high exception reporting for COPD patients. At this inspection data we looked at showed that exception reporting was currently at 20% representing 11 patients. The practice was aware and could explain the reasons why they excluded. The practice had a high exception reporting for cervical screening but was aware of the reasons and expected improvement having addressed the issue.

One of the GPs had taken over responsibility for diabetes and took part in the CCG initiated Diabetes in Community Care Extension (DiCE) clinic held at the practice along with a specialist consultant.

We looked at some previous minutes of meetings (April, June and August 2017) which demonstrated attendance from salaried and Locum GPs. The meetings discussed issues such as safeguarding, medicines and medicine alerts, significant events, and long term conditions.

Audits we looked at referenced quality standards and the findings were discussed at the clinical meeting. Audits we looked at were detailed and had identified areas for improvement.