Dr Kiran Kunwar

Quality Report

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 2 June 2015 and 2 July 2015. Breaches of legal requirements were found and we told the provider of our intention to take enforcement action.

We received representations from the provider informing us that they would remedy any breaches and enforcement action would be disproportionate. We undertook this focused inspection to check whether the practice was making progress in meeting legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dr Kiran Kunwar on our website at www.cqc.org.uk

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

- Practice patients were at serious risk of harm.

Summary of findings

- The safeguarding policy had been updated with local contacts and staff were familiar with this information.
- The practice was able to demonstrate that staff were supported and there were opportunities for learning. However, some clinical staff relied on outdated reference material to maintain their clinical practice.
- The practice had secured external consultancy advice on practice management. We saw that policies and procedures were in the process of being reviewed, updated and tailored to the practice.
- The incident reporting procedure had been reviewed. The practice kept notes of monthly meetings and incident reports were shared with the staff.
- Infection control practice had improved. The practice was less cluttered, the cleaning schedule had been reviewed and the practice had conducted regular (six monthly) audits of infection control.
- The practice now stocked emergency oxygen as well as a defibrillator and emergency medicines. Staff knew where the emergency equipment was located.
- Patients were at significant risk of harm through poor record keeping. The practice ran parallel computerised and paper recording systems and saw no risk in doing so. We found that the computer records did not always match the paper records and the electronic records were not comprehensive.
- The GP principal had increased their use of 'read codes' in the electronic records since our previous inspection but these were not being used systematically.
- The GP principal's ability to use the electronic record system remained very limited. They were unable to run automated searches, reports and audits and relied on an external contractor to carry out these sorts of tasks.
- No new members of staff had been recruited since the last inspection and we did not verify the recruitment procedures. The relevant policies had been updated.
- The practice had responded to a highly critical external report into the quality of their record keeping by increasing the level of detail used when recording consultations and using read codes. The practice had not undertaken any further investigaton into the underlying safety of care as a result.

Although the practice had made some improvements since our last inspection, we were not assured that the practice learned effectively from the evidence about the quality of its service. The practice did not demonstrate the capability to improve to the required standard to meet the regulations.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The practice had made some improvements to its safety systems, but was still failing to meet legal requirements.

Are services well-led?
We found continued failings in governance at the practice, for example, poor clinical record keeping. This was putting patients at significant risk of harm.

Dr Kiran Kunwar

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Kiran Kunwar

Dr Kiran Kunwar provides NHS primary medical services to around 1,460 patients in Southall, in the London Borough of Hounslow. The practice has one surgery, known as North Hyde Medical Practice. The service is provided through a General Medical Services contract.

The current practice staff team comprises one full-time principal GP (who owns the practice), a part-time practice nurse, one permanent receptionist and two temporary receptionists. The practice also contracts a data summariser to assist with maintaining the electronic patient records system, who attends the practice once a month. The clinical staff and receptionists in this practice are female.

The practice is open between 9.15am-1.00pm and 4:45pm-6.30pm on weekdays with the exception of Wednesday when the surgery is closed after 1.00pm. Appointments are available from 10.00am in the morning and 5.00pm in the early evening until the practice closes. Telephone consultations with a GP are also available at these times. The GP undertakes home visits for patients who are housebound or are too ill to visit the practice.

The practice has opted out of providing out-of-hours services to its own patients. Patients can use the out-of-hours primary care service provided locally by Care UK. Patients ringing the practice when it is closed are provided with recorded information on the practice opening hours and instructions to call the "111" telephone line for directions on how to access urgent and out-of-hours primary medical care or, in an emergency, to attend A&E.

The practice has higher than average proportions of adults in the 20-39 and 55-59 age ranges and relatively few patients over the age of 65 years or with long-term limiting health problems. The majority of registered patients are from a minority ethnic background, with patients predominantly originating from Punjabi and Sikh backgrounds. The overall income deprivation level is close to the national average but children in the area are more likely to live in deprived circumstances than the national norm.

The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures; maternity and midwifery services; and treatment of disease, disorder and injury.

Why we carried out this inspection

We carried out an announced comprehensive inspection of this practice on 2 June 2015 and 2 July 2015. Breaches of legal requirements were found and we told the provider of our intention to take enforcement action.

We received representations from the provider informing us that they would remedy any breaches and enforcement action would be disproportionate. We carried out this focused inspection to assess whether the practice had made progress in meeting legal requirements.

We carried out the focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of

Detailed findings

our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. In particular we reviewed information shared with us by NHS England following their visits to the practice on 6 October 2015 and 5 December 2015 and 5th January 2016. We carried out an announced visit on 4 February 2016.

During our visit we:

- Spoke with the GP principal and the interim practice managers
- Reviewed an anonymised sample of the personal care or treatment records of patients
- Observed the premises and equipment
- Reviewed policy documents, written procedures, audits and other monitoring documents

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.

Are services safe?

Our findings

Practice patients remained at significant risk of harm.

The practice had updated the safeguarding policies and procedures with detailed contact details for local safeguarding leads. This included relevant contacts in relation to children's services and vulnerable adults. This information was kept in a central file in reception. Staff had been trained on safeguarding to the appropriate level.

We were told that there were no children with social services' involvement on the patient list at present and the practice had only been involved in one safeguarding case some years previously.

The GP principal initially told us that the incidence of abuse was likely to be low in the Punjabi-speaking local community. They subsequently clarified this statement after the visit. They said that rates of abuse were not necessarily lower but staff members' shared cultural background with many patients meant they were more likely to be able to identify the signs of abuse.

The GP principal also said they did not know how to flag children 'at risk' on the computer records system should the need arise.

We were not assured that all staff maintained their professional skills to a level to provide care safely. The practice had reviewed its recruitment and induction procedures and updated these. The GP principal carried out appraisals with the practice nurse and administrators and had evidence of this. Clinical staff kept a record of continuing personal development, for example, courses and learning meetings attended. However, we were concerned by some of the methods clinical staff used to maintain their skills and knowledge day to day. The doctor told us they sometimes consulted their medical text book as a source of reference (The Principles and Practice of Medicine by Stanley Davidson). This is a highly regarded, standard text book but the doctor was using the same edition they had possessed since starting as a junior doctor in the early 1970s. This was not suitable for use as current reference material.

We asked the doctor if they consulted current resources, for example, the internet. They said they did and described how they performed free text searches using a general internet search engine for specific diagnoses. They were unaware of, and so did not use, internet resources specifically designed for use by clinical practitioners. The risk of returning poor quality and misleading information from general internet search engines is high.

We saw some areas of improvement since our last visit. The practice displayed information about the availability of chaperones in the waiting room. There was no male chaperone normally available however.

The practice had obtained emergency oxygen and staff knew where this was located in the event of an emergency.

The incident reporting procedure had been reviewed. The practice kept notes of monthly meetings and incident reports were shared with the staff.

Infection control had improved. The practice was less cluttered, the cleaning schedule had been reviewed and the practice had conducted regular (six monthly) audits of infection control. The most recent audit had identified areas for improvement. It was not clear from the audit report which actions had been addressed and who was responsible. However staff were able to separately confirm that actions had been completed or were in process.

The practice was able to demonstrate that equipment had been calibrated and appropriate risk assessments had been carried out, for example in relation to fire safety and the risk of Legionella (and Pseudomonas) infection. The practice had acted on recommendations in relation to its fire safety risk assessment. It had also acted on some but not all of the actions highlighted in the Legionella risk assessment. There was some lack of clarity within the practice over their accountability for addressing these risks.

No new members of staff had been recruited since the last inspection and we did not verify the recruitment procedures. The relevant policies had been updated.

Are services well-led?

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

Our findings

The practice had a visible leader but clinical oversight and learning remained inadequate. Governance particularly around clinical record keeping was poor.

Patients were at risk of harm through poor clinical record keeping. The practice ran parallel computerised and paper recording systems. We found that the computer records did not always match the paper records and the electronic records were not comprehensive. For example, for one consultation record we reviewed there was a different diagnosis noted for the same consultation in the two records. The electronic patient record stated "itchy skin around eyes" with a prescription given for a cream. The written record for the same consultation stated the patient was presenting with male pattern baldness. The doctor told us the patient had attended with baldness and they had made a referral as a result. There was no reference to baldness or the referral on the electronic record of the consultation. The doctor was unable to offer an explanation for the discrepancy during the visit, but even so, would not accept there was any potential problem with this way of record keeping. The doctor told us they found writing paper records 'much easier' than using the computer.

The GP principal had increased their use of 'read codes' in the electronic records since our previous inspection but these were not being used systematically to code diagnoses or symptoms. We asked why the doctor had not coded some diagnoses and conditions in the electronic records we reviewed. The doctor told us that they only coded when they considered this to be clinically appropriate, for example, they said they would not code a symptom such as foot pain. The GP principal was confident they were proficient in the use of read codes. The written notes were inevitably not coded.

The GP principal's ability to use the electronic record system was, by their own admission, limited. This meant they were unable to personally run automated searches, reports and audits and relied on an external contractor, who attended once a month, to carry out these tasks. The practice was completing care plans for patients with complex needs, but the GP principal had trouble accessing these electronically. The continued use of parallel written patient records and inconsistent use of 'read codes' undermined accurate reporting, benchmarking and audit.

Prior to the inspection, NHS England shared the findings of a detailed records review of a sample of patient records from the practice which they carried out on 14 October 2015 with a follow-up visit on 5 January 2016. Their reports found the standard of clinical record keeping was seriously below the standards set out in Good Medical Practice (which sets out the duties of doctors registered with the General Medical Council). Specifically the report stated:

"There were nine examples in which the processing of hospital letters raised some cause for concern. There were six examples in which test results had not been acted upon. There were several examples of referrals for which there was no evidence that other plausible alternative actions were considered. In four cases the clinical content of the medical records contained sufficient information to conclude that the quality of clinical care falls below the standards described in Good Medical Practice."

We asked the GP principal what they had done since receiving these reports. They told us they had increased the level of detail they used when recording consultations and now used read codes in the electronic notes. The practice had not undertaken any further audit of their record keeping or clinical care as a result.

Practice staff told us they had regular opportunities for learning. The GP principal and practice nurse discussed the day's patient list before the surgery (not minuted) and there was a monthly practice meeting with all staff. This did not routinely include discussion of significant events. Significant events were individually documented and we were told were discussed separately as they occurred. The GP attended the local GP network forum and told us this was useful but otherwise had limited local external sources of support and collaboration.

In response to the last inspection report, the practice had secured external consultancy advice on practice management. We saw that policies and procedures were in the process of being reviewed, updated and tailored to the practice. However, the practice did not accept evidence where they were 'outliers' or atypical (for example the practice had very high referral rates) as concerning or meriting further investigation. The possibility that indicators such as high referral rates or evidence of poor record keeping might also reflect suboptimal care for patients had not been seriously considered or investigated.

Are services well-led?

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

The practice obtained feedback from patients through the Friends and Family Test (questionnaire) and a Patient Participation Group. The practice did not use an interpreting service. The clinical staff were able to speak Punjabi and Hindi as well as English. We were told that the practice did not currently have any patients who could not communicate in these languages.

Although the practice had made some improvements since our last inspection, we were not assured that the practice learned effectively from evidence about the quality of its service to ensure care was safe. The practice did not demonstrate the capability to improve to the required standard to meet the regulations.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The practice was not assessing the risks to health and safety of patients and mitigating risks. The practice was not ensuring that all clinical staff were maintaining their skills and competence. Regulation 12 (1)(2)(1)(b)(c)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider could not demonstrate that it had the necessary leadership capacity and oversight to ensure that patients were being appropriately assessed, treated and followed up. The provider did not maintain complete and accurate records in relation to each patient. This undermined the practice's ability to evaluate and improve their service. The provider was failing to assess risks and make necessary improvements. Regulation 17 (1)(2)(a)(b)(c)(e)(f)