Dr Selvaratnam Kulendran

Quality Report

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Date of inspection visit: 10 July 2017
Date of publication: 11/09/2017

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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Selvaratnam Kulendran (also known as Chase Cross Medical Centre) on 28 July 2016. The overall rating for the practice was requires improvement. The full comprehensive report on July 2016 inspection can be found by selecting the 'all reports' link for Dr Selvaratnam Kulendran on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 10 July and 19 July 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 28 July 2016. (We visited the practice twice in July 2017 as the practice manager had informed us they would be unavailable on the 10 July 2017 and therefore we were unable to complete the inspection on that day). This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated as good.

At the inspection on 28 July 2016 we found the following areas of concern:

- The system for reporting and recording significant events required reviewing.
- Recruitment arrangements did not include all necessary employment checks for all staff and did not comply with practice recruitment policy.
- Risk assessments had not been carried out for staff who carried out chaperoning duties.
- All staff had not received and completed required training to carry out their roles effectively, including safeguarding, infection control and information governance.
- Systems in place to monitor repeat prescriptions and safety alerts were not adequate.
- There was no system of continuous quality improvement in place.
- Achievement for childhood immunisations was below average.

Summary of findings

- There was no patient participation group (PPG) or equivalent arrangement in place to support the collecting of feedback from patients about how the practice was run.

Our key findings at the inspection in July 2017 were as follows:

- There was an effective system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- The practice had adequate arrangements in place to respond to emergencies and major incidents.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Exception reporting for Mental Health indicators remained above average.
- Achievement for childhood immunisations was in line with national averages.
- Staff had completed information governance, safeguarding and infection control training.
- The provider had an improvement plan for the practice, however they were unable to demonstrate how progress towards achieving the planned improvements was being measured or achieved.
- The practice still did not have a PPG in place although efforts were being made to form one.

In addition, at the inspection on 28 July 2016 we told the provider they should:

- Review systems to identify carers in the practice to ensure they receive appropriate care and support.
- Consider ways to support patients who have a hearing impairment.
- Display notices in the reception areas informing patients that interpreting services are available.

At the inspection in July 2017 we found:

- The patient registration form was updated following the inspection to include a question about whether or not the patient was a carer. We saw information on display and in a folder in the waiting area about available support for patients who were carers.
- A hearing loop had been installed.
- A number of notices had been removed from the display whilst the premises were undergoing renovation. We were told a notice about interpreters would be displayed once the renovations were completed.

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

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care, specifically in relation to monitoring practice performance, introducing a programme of continuous quality improvement and seeking patient feedback.

Additionally, the provider should:

- Ensure the care and treatment of patients is appropriate and meets their needs, specifically in relation to patients with poor mental health.

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

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed rates of exception reporting for patients with poor mental health was above average compared to the national average. However the overall rate of exception reporting was in line with local and national averages.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice had a governance framework, which generally supported the delivery of good quality care. However, there were areas that required improving.
- There was a governance framework which generally supported the delivery of the strategy and good quality care. However this was not supported by effective arrangements to monitor and improve quality and identify risk.
- The practice did not have a patient participation group in place.
- There was limited evidence of continuous learning and improvement.

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
Although concerns remained for well led, the provider had resolved the concerns for safety and effective identified at our inspection on 28 July 2017. These applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People with long term conditions
Although concerns remained for well led, the provider had resolved the concerns for safety and effective identified at our inspection on 28 July 2017. These applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Families, children and young people
Although concerns remained for well led, the provider had resolved the concerns for safety and effective identified at our inspection on 28 July 2017. These applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Working age people (including those recently retired and students)
Although concerns remained for well led, the provider had resolved the concerns for safety and effective identified at our inspection on 28 July 2017. These applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People whose circumstances may make them vulnerable
Although concerns remained for well led, the provider had resolved the concerns for safety and effective identified at our inspection on 28 July 2017. These applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People experiencing poor mental health (including people with dementia)
Although concerns remained for well led, the provider had resolved the concerns for safety and effective identified at our inspection on 28 July 2017. These applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Dr Selvaratnam Kulendran

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a lead inspector, a GP specialist adviser and a practice manager specialist adviser.

Background to Dr Selvaratnam Kulendran

Dr Selvaratnam Kulendran's practice, also known as Chase Cross Medical Centre is located in Romford in a converted detached house, providing GP services to approximately 5,556 patients. The practice also responsible for providing GP services to 52 patients at the local care home. Services are provided under a General Medical Services (GMS) contract with NHSE London and the practice is part of the Havering Clinical Commissioning Group (CCG). The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of maternity and midwifery services, treatment of disease, disorder or injury, surgical procedures, diagnostic and screening procedures and family planning.

The practice is a single-handed GP practice and employs one female GP and one male locum GP. The GPs provide 22 sessions from Monday to Friday. The practice employs one practice nurse (female, 21 hours per week). There are four reception staff, two administrative staff and one practice manager.

The practice telephone line opens between 8.30am to 1.30pm and 2.30pm to 6.30pm Monday to Friday. The practice doors were open from 8.45am to 1.30pm and 4.30pm to 7pm, except on Monday and Friday when the practice closes at 7.30pm. The practice is closed from 1pm every Thursdays. Appointments are from 9am to 12pm every morning between Monday and Friday. Appointments in the afternoon are between 4.30pm to 7.30pm on Monday and Friday and from 4pm to 7pm on Tuesday and Wednesdays. Extended hours appointments are offered four days a week, Monday to Friday with the exception of Thursday for 30 minutes. When the practice telephone lines are closed, calls are directed to the out of hours services which are available during practice closure and weekends.

Information taken from Public Health England, shows that the population distribution of the practice is similar to that of the CCG and national average. Life expectancy for males in the practice is 78 years, which is lower than the CCG and national average of 79 years. The female life expectancy in the practice is 83 years, which is lower than the CCG average of 84 years and the same as national average of 83 years. Information published by Public Health England rates the level of deprivation within the practice population group as six on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest.

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Selvaratnam Kulendran on 28 July 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 July 2016 can be found by selecting the 'all reports' link for Dr Selvaratnam Kulendran on our website at www.cqc.org.uk.

We undertook a follow upfocused inspection of Dr Selvaratnam Kulendran on 10 and 19 July 2017. This

Detailed findings

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

During our visit we:

- Spoke with a range of staff (GP, practice manager, nursing and reception/administrative staff).
- Reviewed a sample of the personal care or treatment records of patients.
- Visited the practice location.
- 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 28 July 2016, we rated the practice as requires improvement for providing safe services as the processes in respect of significant event management, legionella, recruitment and management of safety alerts and repeat prescriptions were not adequate to keep people safe. Also not all staff had received safeguarding training.

These arrangements had improved when we undertook a follow up inspection in July 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

At the inspection on 28 July 2016 we found the incident reporting form lacked details of learning outcomes and improvements to be made to prevent incidents occurring again. We found improvements had been made when we inspected the practice in July 2017.

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The form included details of learning outcomes and improvements made to prevent a repetition.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an incident where vaccines had been left out of the fridge by a member of staff, we saw from meeting minutes that the incident was discussed with all staff and staff received relevant training to prevent a repetition.

Overview of safety systems and process

At the inspection on 28 July 2016 we found areas where improvement was required, specifically around safeguarding, background checks, infection control, medicines management, recruitment processes and risk management. At the inspection in July 2017 we found improvements had been made.

- At the inspection on 28 July 2016 we found not all non-clinical staff had completed safeguarding training. At the inspection in July 2017 we found improvements had been made. Staff demonstrated they understood their responsibilities and all but one of the non-clinical members of staff had received training on safeguarding children (level 1) and vulnerable adults relevant to their role.
- At the inspection on 28 July 2016 we found the practice manager, who acted as a chaperone, had not received a Disclosure and Barring Service (DBS) check. At the inspection in July 2017 we saw confirmation that this had now been carried out.
- At the inspection on 28 July 2016 we found the seating in the reception area was made of fabric and some were stained and damaged. The hand wash basins were not suitable for use in the clinical environment. An infection control visit had been carried out by the Clinical Commissioning Group in August 2016 and areas where highlighted requiring action. We saw that all but two of the action points had been completed by the inspection in July 2017. The seating had been replaced with chairs of a more suitable kind. All hand basins and taps had been changed to the correct type in all consulting rooms. However, when we attended on 10 July 2017 we noted that the clinical waste bag had not been marked with the practice code when securing for disposal and that buckets were not kept inverted when not in use. These issues had been rectified when we attended on 19 July 2017. We saw evidence of infection control audits carried out by the practice in October 2016 and June 2017.
- At the inspection on 28 July 2016 we found reception staff were not able to consistently tell us how often uncollected repeat prescriptions were reviewed and followed up, including the review of high risk medicines. At the inspection in July 2017 we found there was a clear and known process for managing repeat prescriptions. A repeat prescription policy was in place and it was followed. We saw appropriate measures were in place to monitor patients prescribed high risk medicines such as warfarin, lithium and methotrexate.

Good

Are services safe?

- At the inspection on 28 July 2016 we found inconsistency in recruitment checks undertaken prior to employment for the recently employed staff. There were no records of immunisation details for relevant staff and there were no records of written references documented as outlined in the practices recruitment policy. At the inspection in July 2017 we saw immunisation records for clinical staff (non-clinical staff were not required to be immunised). We looked at the staff file for the most recent recruit (November 2016) and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification and references. Disclosure and Barring Service checks were only carried out for clinical staff and the practice manager who acted as a chaperone.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. At the inspection on 28 July 2016 we found the practice had up to date fire risk assessments but did not carry out fire drills or fire alarm tests. At the inspection in 10 July 2017 we saw records of fire drills/evacuations that had been carried out in April and July 2017. We also saw that that all fire safety equipment had been serviced in May 2017.
- At the inspection on 28 July 2016 we found the practice had not carried out a risk assessment for legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). At the inspection in July 2017 we saw an assessment had been carried out by a professional company in September 2016. This risk assessment contained a control scheme which listed certain actions to be carried out to maintain the safety of the water system. It was unclear from the report whether these actions were to be carried out by the company or the practice. The practice manager undertook to follow this up with the company and following the inspection we received confirmation that a regular assessment and cleaning programme was in place and training for staff to complete the in-house water safety checks had been arranged.

Arrangements to deal with emergencies and major incidents

- At the inspection on 28 July 2016 we found the practice did not have a defibrillator. They had a documented risk assessment, which showed they would be able to use another GP practice's defibrillator in an emergency. However, the practice was not able to provide evidence that the neighbouring practice had agreed to this. The position remained the same when we attended on 10 July 2017 however we were told the local pharmacy had also agreed to the practice using their defibrillator in the case of an emergency. We checked this with the pharmacy who confirmed the defibrillator was available for use by all of the local community, however there were slight differences in the opening hours of the pharmacy and the practice. When we attended on 19 July 2017 we saw evidence that the practice had ordered a defibrillator and delivery was confirmed subsequently.
- At the inspection on 28 July 2016 we found the practice's business continuity plan did not include emergency contact numbers for staff. At the inspection in July 2017 we saw this had now been amended and included contact numbers for all staff and service providers.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 28 July 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of needs assessments, management, monitoring and improving outcomes, staff training and childhood immunisations needed addressing.

These arrangements had mostly improved when we undertook a follow up inspection in July 2017. The practice is now rated as good for providing effective services.

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

- At the inspection on 28 July 2016 we found the practice had higher than average exception

  reporting for mental health related indicators. (Exception reporting is the removal of patients from Quality Outcomes Framework (QOF) calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The exception reporting was 44%, which was higher than the clinical commissioning group (CCG) average of 11% and national average of 13%.

  At the inspection in July 2017 we found the practice's rate of exception reporting for most of the mental health related indicators was higher than the local and national averages. For example, data from 1 April 2015 to 31 March 2016 showed for the indicator "percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate", the practice's rate of exception reporting was 44% compared to the CCG rate of 11% and the national rate of 12%. There was no evidence of steps taken to address this issue by the practice.The practice's overall exception reporting rate for 2015/16 was 12% which was in line with the local and national average of 10%.

Effective staffing

At the inspection on 28 July 2016 we found staff had not received training in information governance. At the inspection in July 2017 we saw staff had completed information governance training in December 2016 and January 2017.

Supporting patients to live healthier lives

At the inspection on 28 July 2016 we found childhood immunisation rates for the vaccinations given were comparable to CCG but lower than national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 80% to 87% and five year olds from 79% to 86%.

At the inspection in July 2017 the most recent published data (1 April 2015 to 31 March 2016) showed childhood immunisation rates for the vaccinations given were lower when compared to the national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The published data showed practice had not achieved the target in any of the four areas. These measures can be aggregated and scored out of 10, with the practice scoring 8.3 (compared to the national average of 9.1).

The practice manager told us the published figures for the practice were incorrect and they had achieved at least 90% for each area. We saw they had been communicating with the local CCG and with the NHS system which held the relevant patient data in order to have the errors rectified. Following the inspection we received evidence from the NHS electronic patient record systems to show that immunisation rates for both under two year olds and five year olds for the relevant period was above 90% for all areas. The practice manager undertook to continue to investigate the apparent issue with data collection in respect of childhood immunisations for this practice to ensure it was correct in future.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 28 July 2016, we rated the practice as requires improvement for providing well-led services as the governance structure was not organised and did not effectively support continuous quality improvement.

We issued a requirement notice in respect of these issues and found some improvement in the arrangements when we undertook a follow up inspection of the service in July 2017. However, further improvement was required. The practice remains rated as requires improvement for being well-led.

Governance arrangements

- At the inspection of 28 July 2016 we found there was no programme in place for continuous clinical and internal auditing used to monitor quality and to make improvements.
- We were provided with the practice's improvement plan which included aims such as reducing avoidable A & E attendances, to improve care for diabetic patients and to generally improve the quality of care for patients. We were told the practice reviewed local statistics and performance of the practice against other local practices within the clinical commissioning group (CCG
- At the inspection of 28 July 2016 we found there were no systems in place to monitor or manage staff training. The management team had no oversight of the training requirements for individuals to carry out their roles and lacked any record keeping. At the inspection in July 2017 we saw the practice manager now maintained records of staff training and a spreadsheet which detailed the training staff were to undergo annually. However, this document did not include a record of the dates when the training was completed which meant this information was not readily available or easily accessible during the inspection.

Seeking and acting on feedback from patients, the public and staff

- At the inspection on 28 July 2017 we found the practice had a virtual patient participation group (PPG) and we saw information in the waiting area to recruit patients for the PPG. However, the practice could not evidence how the virtual PPG had influenced any improvements in the practice and despite efforts to encourage patients to join they had been unable to set one up. They told us the virtual patient participation group had not been successful. Following the inspection the practice manager informed us they had communicated with two patients who may be interested in joining the PPG and additional prospective members were being sought.
- We saw that a patient survey had been carried out in June 2016 (over 75s) regarding health checks. We were told the practice had chosen this patient group as they tended not to express their views about the service. The results showed the respondents were highly satisfied with the service they had received.

Continuous improvement

- At the inspection in July 2017 we were told the practice manager was training with the CCG to become a quality improvement lead for the local network. This training process was still underway at the time of the inspection. It was hoped that as a result of this training the practice would have the knowledge to have a more effective quality improvement process and generally improve standards at the practice.

This section is primarily information for the provider

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not do all that was reasonably practicable to ensure effective systems and processes were in place, specifically by failing to: • Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care, specifically in relation to monitoring practice performance, introducing a programme of continuous quality improvement and seeking patient feedback. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.