New Road Medical Centre

Quality Report

New Road Medical Centre
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Date of inspection visit: 11 July 2017
Date of publication: 27/07/2017

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?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection Dr's P L & S Kaul and Dr G K Gill also known as New Road Medical Centre on 22 November 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the November 2016 inspection can be found by selecting the 'all reports' link for Dr's P L & S Kaul and Dr G K Gill on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 11 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 were identified in our previous inspection on 22 November 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.

Our key findings were as follows:

- Since our November 2016 inspection, the practice established effective processes and practices to keep patients safe and safeguarded from abuse. For example, staff operated a comprehensive and well embedded system for monitoring and tracking patients who failed to attend hospital appointments.
- During this inspection, we saw completed risk assessments which demonstrated effective management of risks such as fire safety and control of substances hazardous to health.
- Following our previous inspection, the practice reviewed arrangements for dealing with medical emergencies. At this inspection, we saw evidence of actions taken to ensure timely access to appropriate emergency medicines and equipment.
- When we carried out our November 2016 inspection, Quality and Outcomes Framework (QOF) data we viewed showed areas where the practice was performing below local and national averages. During this inspection, staff explained that an action plan had been developed to improve the practice performance. Published and unverified data showed that QOF outcomes had improved.
- Documents provided by the practice as part of this inspection, demonstrated effective use of clinical audits to drive improvements in patient care.

Summary of findings

- Further actions taken to identify carers since the previous inspection, showed a slight increase in the practice carers list. Staff explained that carers were offered support where needed and the new patient registration form included questions which identified carers. We were told that reception staff actively updated records when patients attended the practice. A carer's corner which included information on various support groups was located in the reception area.
- Since the previous inspection, the practice developed and reviewed a number of policies and procedures to govern activity, which all staff had access to. Oversight of procedures and risks had improved since the previous inspection. As a result, arrangements for managing pathology results, practice performance and patients who failed to attend appointments had improved.

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, on 22 November 2016, we rated the practice as requires improvement for providing safe services as some areas relating to safe care needed improving. These arrangements had significantly improved when we undertook a follow up inspection on 11 July 2017. For example:

- At this inspection, we saw a well embedded comprehensive system for monitoring and tracking patients who failed to attend hospital appointments.
- Documentation provided by the practice as part of this inspection, showed the management of risks such as fire safety and control of substances hazardous to health were well managed.
- Since the November 2016 inspection, the practice reviewed arrangements for dealing with medical emergencies. Potential risks had been identified and access to adequate medicines improved.

Are services effective?

Good

At our previous inspection, on 22 November 2016, we rated the practice as requires improvement for providing effective services. This was because some clinical performance was below local and national averages and the practice were unable to demonstrate an effective system for driving improvements in patient care. These arrangements had significantly improved when we undertook a follow up inspection on 11 July 2017. For example:

- The practice had commenced keeping records of clinical and multidisciplinary meetings. We saw evidence that clinical staff were discussing and sharing best practice regarding some of the more complex cases they had seen.
- At this inspection, staff explained that the practice developed an action plan which targeted specific clinical areas where performance was below local and national averages. Data from the Quality and Outcomes Framework (QOF) showed clinical performance had improved.
- During this inspection, documents provided by the practice demonstrated effective use of clinical audits to drive improvements in patient care.
- We saw that the practice operated an effective system for reviewing and acting on pathology results and hospital correspondences.

Summary of findings

Are services well-led?

Good

At our previous inspection, on 22 November 2016, we rated the practice as requires improvement for providing well-led services, as some governance arrangements needed improving. These arrangements had significantly improved when we undertook a follow up inspection on 11 July 2017. For example:

- Since the previous inspection, the practice governance framework had been strengthened. We saw effective arrangements to monitor performance; improve quality and manage risk. Oversight of these processes was well managed.
- Processes for managing pathology results and information received from secondary care had significantly improved since our previous inspection.
- We saw evidence of regular meetings such as general practice and clinical meetings, which had been minuted and distributed to all staff members.
- The practice continued seeking feedback from staff and patients via meetings and internal surveys, which they acted on. Staff reviewed the July 2017 national GP survey and developed action plans to further improve patient satisfaction. The patient participation group was active.

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 the concerns for safety, responsive and well-led identified at our inspection on 22 November 2016 which 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
The provider had resolved the concerns for safety, responsive and well-led identified at our inspection on 22 November 2016 which 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
The provider had resolved the concerns for safety, responsive and well-led identified at our inspection on 22 November 2016 which 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)
The provider had resolved the concerns for safety, responsive and well-led identified at our inspection on 22 November 2016 which 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
The provider had resolved the concerns for safety, responsive and well-led identified at our inspection on 22 November 2016 which 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)
The provider had resolved the concerns for safety, responsive and well-led identified at our inspection on 22 November 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

New Road Medical Centre

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 New Road Medical Centre

Dr's P L & S Kaul and Dr G K Gill also known as New Road Medical Centre is located in Walsall, West Midlands in a multipurpose modern built NHS building, providing NHS services to the local community. Dr's P L & S Kaul and Dr G K Gill consist of two sites both managed under separate General Medical Services (GMS) contracts with the Clinical Commissioning Group (CCG). GMS is a contract between general practices and the CCG for delivering primary care services to local communities. Dr's P L & S Kaul and Dr G K Gill is part of Walsall Alliance, which is a Federation consisting of 31 practices in Walsall enabling collaboration on a wider population basis.

Based on data available from Public Health England, the levels of deprivation in the area served by New Road Medical Centre are below the national average, ranked at four out of 10, with 10 being the least deprived. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial.

The practice population group from birth to ages 85 and over were comparable to local and national averages for most age groups. For example, patients' aged from birth to four years old were comparable to local and national averages. Patients aged 60 to 69 were also comparable to local and national averages however, patients aged 70 to79 were above average.

The patient list is 1,896 of various ages registered and cared for at the practice. Services to patients are provided under a General Medical Services (GMS) contract with the Clinical Commissioning Group (CCG).

The surgery has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The surgery is situated on the ground floor of a multipurpose building shared with other health care providers. On-site parking is available with designated spaces for cyclists and patients who display a disabled blue badge. The surgery has automatic entrance doors and is accessible to patients using a wheelchair.

The practice staffing comprises of three GP partners (two male & one female), on regular female locum GP, one independent nurse prescriber, two practice nurses, one practice manager, a team of secretaries and receptionists. Practice staff worked across both sites. The practice is a student nurse teaching practice offering placements and mentoring for students from the local university.

The practice is open between 8.30am and 6.30pm on Mondays, Wednesdays and Fridays. Tuesday opening times are between 8.30am and 7.30pm; Thursdays are from 8.30am to 1pm.

GP consulting hours are from 9.30am to 11.30am and 4pm to 6pm Mondays; 8.40am to 10.30am and 5pm to 7pm Tuesdays; 8.40am to 10.30am and 4pm to 6pm Wednesdays; 9.30am to 11.30am Thursdays; 9.30am to 11.30am and 3pm to 4pm Fridays. The practice has opted out of providing cover to patients in their out of hours period. During this time services are provided by NHS 111. During in service closure times services are provided by WALDOC (Walsall doctors on call).

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection, of Dr's P L & S Kaul and Dr G K Gill on 22 November 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. This was because the provider did not ensure that procedures related to safeguarding were effectively followed; oversight of governance arrangements and management of some risks were not effective. The full comprehensive report following the inspection in November 2016 can be found by selecting the 'all reports' link for Dr's P L & S Kaul and Dr G K Gill on our website at www.cqc.org.uk.

We undertook a follow up focused inspection, of Dr's P L & S Kaul and Dr G K Gillon on11 July 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

Before visiting, we reviewed a range of information we hold about the practice and asked the practice to provide evidence of progress made since the November 2016 inspection. We carried out an announced visit on 11 July 2017. During our visit we:

- Spoke with a range of staff including GPs, a practice nurse, an administrator and a practice manager.
- Observed how patients were being cared for in the reception area and spoke with members of the practice patient participation group.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- 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 22 November 2016, we rated the practice as requires improvement for providing safe services as systems for managing some risk were not followed effectively and assessments to mitigate risks in some areas had not been carried out.

These arrangements had significantly improved when we undertook a follow up inspection on 11 July 2017. The practice is now rated as good for providing safe services.

Overview of safety systems and process

We saw clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. For example.

- Although the practice had policies and processes in place for raising safeguarding concerns. During our November 2016 inspection, staff was unable to demonstrate where they had appropriately followed up children who failed to attend hospital appointments. Since the previous inspection, the practice developed a comprehensive system for monitoring and tracking patients who failed to attend hospital appointments. Staff we spoke with explained that members of the nursing team carried out searches to identify patients who failed to attend either a hospital or surgery appointment. We saw evidence of appropriate actions taken by clinicians to follow up identified patients. Records also showed proactive communication with health visitors and safeguarding teams.

Monitoring risks to patients

At this inspection, we saw that risks to patients were assessed and well managed.

- Procedures in place for monitoring and managing risks to patient and staff safety had improved since our previous inspection. The practice provided copies of a fire risk assessment, fire drills and a record of weekly alarm fire alarm tests which had been carried out since our previous inspection.
- Control of substances hazardous to health (COSHH) data sheets we viewed showed that risks had been identified to ensure those who used chemicals in the workplace did so safely. We saw that risk of harm to users or the environment was well documented.
- When we carried out our November 2016 inspection, staff provided evidence of completed water temperature tests in line with legionella requirements (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, the practice was unable to provide a copy of their legionella risk assessment. During this inspection, the practice provided copies of a risk assessment which they obtained from the property owners.

Arrangements to deal with emergencies and major incidents

During our previous inspection, we saw adequate arrangements in most places to respond to emergencies and major incidents. At this inspection, we saw that arrangements had improved. For example,

- We saw that the practice had reviewed potential risks and had access to adequate medicines. Staff also explained that emergency arrangements with a neighbouring pharmacy had been formally established.
- Since our previous inspection, the practice carried out an assessment to ensure the location of the defibrillator and oxygen was easily accessible for all staff. During this inspection, we saw the oxygen and defibrillator both located in a clinical room.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection, on 22 November 2016, we rated the practice as requires improvement for providing effective services as the practice did not develop a plan to specifically target clinical areas where performance was below local and national averages. Completed clinical audits did not demonstrate that they were being used to drive quality improvement in patient care.

These arrangements had significantly improved when we undertook a follow up inspection on 11 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. Staff we spoke with as part of this inspection, explained that minutes of internal clinical meetings as well as multidisciplinary meetings were kept and distributed to all clinicians. We saw evidence of where clinical staff discussed and share best practice regarding some of the more complex cases they had seen.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results remained at 86% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 95%.

Previous data showed that the practice was an outlier for some QOF (or other national) clinical targets. Data from 2015/16 QOF year showed areas where performance had declined. Staff explained that the practice developed an action plan, which targeted specific clinical areas. Unverified data from 2016/17 QOF year showed improvements. Data also showed that exception reporting was below CCG and national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). For example:

- The percentage of patients with diabetes, on the register whom had a blood sugar reading which showed that the condition was being controlled was 68%. Unverified data showed performance improved to 80%, compared to CCG average of 79% and national average of 78%.
- 71% of patients with a mental related disorder had a comprehensive, agreed care plan documented in their record in the preceding 12 months, compared to the CCG average of 92% and national average of 88%. Unverified data provided during the inspection, showed performance had improved to 100%, with 0% exception reporting rate.
- The percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had a review undertaken including an assessment of breathlessness using recognised methods was 77%, compared to CCG average of 92% and national average of 90%. Unverified data provided during the inspection, showed 97% received a review using recognised methods.
- Patients with rheumatoid arthritis, on the register who had a face-to-face annual review in the preceding 12 months increased from 86% to 88% compared to CCG average of 98% and national average of 92%. With an exception reporting rate of 6% compared to CCG average of 2% and national average of 4%.
- The percentage of patients with atrial fibrillation (an irregular and sometimes fast pulse) treated using recommended therapy declined from 96% to 90%, compared to CCG average of 98% and national average of 97%. Unverified data provided during the inspection, showed 100% were treated using recommended therapy, with a 1% exception reporting rate.
- Data provided by the practice showed that 100% of patients diagnosed with dementia had a care plan in place in the past 12 months.

Staff we spoke with was able to demonstrate actions taken since the previous inspection to specifically target lower performing QOF domains. We saw that the practice followed established protocols for managing exception reporting such as sending up to three appointment reminder letters; this was followed up by phone calls to encourage patients to attend appointments and required reviews. Members of the nursing team explained that they

Good

Are services effective?

(for example, treatment is effective)

maintained close contact with COPD nurses and utilise this to further improve performance. The practice continued receiving support from a diabetic nurse specialist who held fortnightly practice based clinics. Unverified data showed patients on the diabetes register that had a record of a foot examination and risk classification improved from 90% to 94% compared to CCG and national average of 91%.

Staff explained that since the previous inspection, they had addressed issues relating to the management of patients in receipt of medicines used to treat types of mental health problems. We were told that patients who failed to respond to appointment invites received a follow up letter and the practice liaised with the community mental health team. We were also told that appropriate actions were taken regarding patients who had moved out of the practice catchment area. Unverified data provided by the practice showed that patients were being managed appropriately. The practice provided evidence of further clinical audits carried out since the November 2016 inspection. For example, the practice carried out an audit to identify whether patient diagnosed with type two diabetes were being managed in line with NICE guidelines. The audit identified that 19% did not have a risk score calculated where a decision to offer recommended medicines was recorded. The practice developed an action plan, which involved inviting identified patients in for a review. Staff explained that a repeat audit had been planned for February 2018 to assess whether improvements had been achieved.

Coordinating patient care and information sharing

At this inspection, staff we spoke with explained that all incoming correspondence such as letters and pathology results was checked electronically by clinicians. During this inspection, we saw evidence that all tasks had been viewed and actioned.

Supporting patients to live healthier lives

The practice continued to demonstrated how they encouraged patients to attend national screening programmes for cervical, bowel and breast cancer screening by using information in different languages and for those with a learning disability. The practice ensured a female sample taker was available. Unverified data provided by the practice showed that the uptake of cervical screening remained above local and national averages. For example, 2016/17 data showed an uptake rate of 84%, compared to CCG average of 81% and national average of 82%. Unverified data provided by the practice showed that the uptake of breast cancer screening increased from 70% to 72%; however, persons, 60-69, screened for bowel cancer remained below local and national average. For example, 57%, compared to CCG average of 73% and national average of 74%. Staff we spoke with explained that they proactively contacted patients and arranged for bowel cancer testing kits to be sent out to patients.

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 November 2016 inspection, we rated the practice as requires improvement for providing well-led services as some governance arrangements needed improving. These arrangements had significantly improved when we undertook a follow up inspection on 11 July 2017. For example:

Governance arrangements

When we carried out our November 2016 inspection, we saw a staffing structure and staff we spoke with were aware of their own roles and responsibilities; and in most areas the responsibilities of the wider team. However, although there were some governance arrangements in place, some systems and processes were not well established or operated effectively. At this inspection, we saw significant improvements. For example:

- We spoke with clinical and non-clinical staff who clearly explained lead roles and responsibilities.
- Members of the management team explained that policies and procedures had been reviewed since the previous inspection. We were presented with evidence of a rigorous safeguarding procedure, which staff follow when patients failed to attend secondary care appointments.
- Oversight of risks was appropriately managed. For example, at this inspection, we saw evidence of completed risk assessments which showed that risk associated with anticipated emergency situations had been explored, and health and safety measures were effectively managed.
- Since our previous inspection, the practice assessed the location and storage of emergency medicines and equipment. As a result, staff explained that emergency equipment had been moved to clinical rooms for more timely access.
- During this inspection, staff explained that a new policy and procedure to manage incoming mail, such as pathology reports had been implemented. Guidance around effective use of the practice computer system was distributed to staff members. Staff explained that they were now operating a more effective and timely process for actioning and distributing medical information throughout the practice.
- Since the previous inspection, the practice developed an action plan aimed at targeting specific clinical areas where performance fell below national and local averages. For example, staff explained that clinicians met to identify and discuss patients who were not controlling their diabetes. Staff also explained that patients who frequently attended secondary care due to diabetes management were contacted and booked in with the diabetic nurse.
- Although the practice operated a programme of continuous clinical and internal audits, during our previous inspection audits we viewed did not show quality improvements. In addition, the monitoring of patients with long-term conditions and those experiencing poor mental health was not effective in relation to their care and treatment. At this inspection, we saw evidence of effective use of clinical audits aimed at driving quality improvements. Staff explained that audits triggered the development of policies and changes in procedures. For example, we saw evidence of a well embedded policy and procedure to ensure all patients in receipt of medicines to treat types of mental health problems received an annual electrocardiogram (ECG) tests, (a test which measures the electrical activity of the heart to show whether or not it is working normally). Staff we spoke with as part of this inspection, also explained following an audit of patients with type two diabetes the practice identified patients categorised patients into low, medium and high priority based on level of risk. We saw that all patients classed as high priority were invited for a consultation to discuss medicine management and to encourage compliance with recommended interventions.

Leadership and culture

Staff we spoke with explained that since the November 2016 inspection, a formal internal meeting structure had been implemented. We saw evidence of meeting minutes, which followed a structured standing agenda item.

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

Evidence provided by members of the management team as part of our follow up inspection, showed continued discussions regarding outcomes of the national GP patient survey. We saw evidence of meetings with the patient participation group (PPG), internal patient surveys and a

Are services well-led?

Good

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

review of action plans to improve patient satisfaction. PPG members we spoke with explained that the practice discussed the NHS Friends a Family test results and outcomes of internal survey with the group. Since the previous inspection, the practice responded to patients' feedback regarding access to a female GP. As a result, staff explained that the practice recruited a locum GP and there were plans to increase this provision in September 2017 with the recruitment of a female GP partner. Staff we spoke with was aware of areas of patients satisfaction which had improved and areas which required further improvement following the July 2017 national GP survey.