Parkview Surgery Edgware

Quality Report

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

Ratings

Overall rating for this service	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 Parkview Surgery on 21 June and 5 July 2017. The overall rating for the practice was requires improvement. The full comprehensive report on the June and July 2017 inspection can be found by selecting the 'all reports' link for Dr T Ganesh and Dr S Shanmugaratnam on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 26 January 2018 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 21 June and 5 July 2017. 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:

- Staff were aware of their responsibilities in relation to information governance, and had undertaken information governance training.
- New systems and processes had been developed to improve record keeping within the practice to ensure that a complete and contemporaneous record is kept in respect of each service user in an accessible way. Staff had also received record keeping training.
- New processes had been put in place to improve areas where patient outcomes were below average, in particular in relation to the proportion of patients excepted from the Quality and Outcomes Framework and the uptake of cancer screening and childhood immunisation programmes.
- The minutes of internal and external meetings were being taken consistently.
- The significant events process had been reviewed to ensure significant events were promptly recorded.
- The process for checking uncollected prescriptions had been reviewed and a new prescribing policy had been developed.
- Care plans developed for those patients that required these were given to patients to take home for their information following their consultations.
- The practice had reviewed areas where patients rated the service below average as part of the NHS GP Patient Survey and had set up a new Patient Participation Group to optimise patient feedback.
- The interpreting service was advertised to patients at reception and via posters and leaflets.
- The allocation of tasks and responsibilities within the practice had been reviewed to ensure that all staff were clear about their roles

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

Parkview Surgery Edgware

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team consisted of two CQC inspectors and a GP Specialist Advisor.

Background to Parkview Surgery Edgware

Parkview Surgery Edgware is located in a residential area in Burnt Oak, North London. The practice is located in shared rented premises on a residential street. There is on street parking in front of the surgery, a bay for parking for disabled patients in front of the surgery and a bus stop approximately ten minutes' walk from the practice.

The practice also provides services from a branch location, which is approximately a mile away. The branch practice is located within shared premises, situated within the Grahame Park housing estate. There are approximately 6000 patients registered at the practice.

Statistics shows high income deprivation among the registered population. The registered population is slightly higher than the national average for those aged between 25-44. Patients registered at the practice come from a variety of ethnic backgrounds including Asian, Western European, Eastern European and Afro Caribbean. The practice is open from 8 am to 6:30 pm Monday to Friday. The practice offers extended hours appointments from 7:15 to 8 am on Thursday mornings, from 7:30 am to 8 am on Friday mornings and from 8 am to 11 am on one Saturday in four.

The practice is registered with the Care Quality Commission to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Maternity and midwifery services
- Surgical procedures

Why we carried out this inspection

We undertook a comprehensive inspection of Parkview Surgery Edgware on Wednesday 21 June and Wednesday 5 July 2017 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 in June and July 2017 can be found by selecting the 'all reports' link for Dr T Ganesh and Dr S Shanmugaratnam on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Parkview Surgery Edgware on Friday 26 January 2018. 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

During our visit we:

- Spoke with a range of staff (Practice Manager and GPs).
- Reviewed a sample of the personal care or treatment records of patients.

Detailed findings

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

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 effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 21 June and 5 July 2017, we rated the practice as requires improvement for providing effective services as the arrangements in respect of exception reporting, information governance and record keeping, care plans, childhood immunisation targets and the advertisement of interpreting services needed improving.

These arrangements had significantly improved when we undertook a follow up inspection on 26 January 2018. The practice is now rated as good for providing effective services.

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). At our previous inspection in June and July 2017, the most recent published results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. However, the practice's exception reporting rate was higher than the local and national average at 13%, compared with a CCG average of 8% and national average of 10%. (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). The practice had significantly higher exception reporting for the management of patients with diabetes. For example, data from 2015/16 showed:

- Performance for diabetes related indicators were mixed; whilst the practice had higher than average achievement rates in several areas, its exception reporting rate was significantly higher than average. Overall the practice achieved 98% of the total QOF points available for diabetes an average of 88% locally and 90% nationally; however, its overall exception reporting rate for diabetes was 16% compared to the CCG average of 10% and national average of 12%.
- The proportion of diabetic patients who had a record of well controlled blood sugar in the preceding 12 months was 81%, which was above the CCG average of 77% and national average of 78% (exception reporting rate was 23% compared with the CCG average of 10% and national average of 9%).
- The proportion of diabetic patients with a record of a foot examination and risk classification in the preceding 12 months was 96% compared to a CCG average 88%, national average 89% (exception reporting rate was 12% compared with the CCG average of 6% and national average of 8%).
- The proportion of diabetic patients with well controlled blood pressure was 93% compared to the CCG average of 90% and national average of 91% (exception reporting rate for this indicator was 9% compared to the CCG and national average of 6%).

At our inspection on 26 January 2018, we asked the Practice Manager and GP partners, what action had been taken since our previous inspection to improve the exception reporting rates for diabetes. We saw evidence of a review of all patients with diabetes who had been exception reported in the past 12 months. Part of this review found there was a misunderstanding by staff of the coding system. Staff had reviewed the QOF exception reporting guidance, and the need for three specific invites to be recorded was highlighted to staff.

The practice nurse had been working to recall patients through letters, telephone calls and coding invitations on the clinical system. The GPs were also working to recall patients through messages on patient prescriptions and when reviewing patient prescription requests. An exception reporting policy had been developed which included robust criteria for exception reporting and staff were instructed to avoid all exception reporting until discussed further with a clinical lead. The practice had undertaken monthly reviews of the exception reporting data and the results showed exception reporting rates had reduced.

Effective staffing

At our previous inspection on 21 June and 5 July 2017 we found staff had received training that included safeguarding, fire safety awareness and basic life support; however there was no formal training provided for staff on information governance.

Good

Are services effective?

(for example, treatment is effective)

At our inspection on 26 January 2018, we saw evidence staff had successfully completed online information governance training and a spreadsheet had been developed to record the dates staff undertook the training and the scores achieved.

Coordinating patient care and information sharing

At our previous inspection we found the information needed to plan and deliver care and treatment was available to relevant staff; however, this was not always stored in a way that was easily accessible to staff. We saw some examples of patient notes where changes to the medicines prescribed had been made, but where there was no note in the record to explain the reason for the change. Further review found that there were documents saved to the system which explained the change (for example, in a letter from a hospital consultation which advised of a revised dose); however, there was a lack of consistency in how this information was stored on the system, which could result in information being overlooked, particularly by a locum GP.

We asked staff what changes had been made since our last inspection to improve these issues. Staff told us previously the clinicians had been reviewing the clinical letters before scanning them into the patient record system. This process had now changed and clinical letters were now scanned daily. The scanned documents were then sent directly to the clinicians to review. Tasks, such as patient recall, were then sent to a designated receptionist to complete. Administration notes were added to patient records each time there was a change to a patient's medicine and when patient reviews were due, messages were passed on to patients via their prescriptions and also by the administration team. This new change to working provided a full audit trail for each document as well as ensuring patient records were updated at the earliest opportunity.

At our previous inspection on 21 June and 5 July 2017 we reviewed examples of patient care plans, which we found to contain an adequate level of detail; however, we were told by the practice that they did not provide patients with a copy of their care plan. At our inspection on 26 January 2018 we found the practice were using asthma and diabetes care plans and providing these for patients. The practice was currently working on providing care plans for frailty patients and identifying any patients who were required to attend the practice for a review. An allocated appointment time on Thursday afternoons had been scheduled for patients who required a review and the practice had developed a template patient care plan for each patient who had been reviewed to take home with them after their appointment.

Supporting patients to live healthier lives

At our previous inspection the practice's uptake for the cervical screening programme was 87%, which was comparable with the CCG average of 78% and the national average of 82%; however, the practice's exception reporting rate was 20%, compared with the CCG average of 8% and national average of 7%.

Childhood immunisation rates for the vaccinations given were below national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice did not achieve the target in any of the four areas. These measures can be aggregated and scored out of 10, with the practice scoring 7.7 (compared to the national average of 9.1).

The practice had not analysed its patient population to try to identify reasons for the below average uptake of screening and immunisation programmes. They were aware that they had a significant proportion of patients who did not speak English as a first language; however, they had not attempted to provide information about these programmes in different languages.

At our inspection on 26 January 2018 we asked staff what action they had taken to address these issues. We were provided with evidence of new documentation to ensure patients were aware that translation services were available at the practice. A new leaflet had been developed which was used to accompany letters sent to patients which instructed patients whose first language was not English, that if any contents of the letter they had received were unclear, to contact the practice for assistance. This leaflet was translated into Albanian, Arabic, Farsi, Gujarati, Polish, Portuguese, Romanian, Somali, Spanish and Tamil. Within the practice there was also a poster translated in these same ten languages which informed patients that interpretation services could be arranged for them. At the reception desk there was a language identifier card which asked patients to point to their language so that an interpreter could be arranged for them.

To reduce the exception reporting rate for cervical screening the practice had undertaken an audit of all the exception codes for cervical smears during the previous five

Good

Are services effective?

(for example, treatment is effective)

years. The results of the audit indicated a staff general misunderstanding of the coding. After discussion and training with staff, this audit was repeated after a three month period and the results showed that no patients had been exception reported for cervical screening during this period and the previous exception reporting rate of 20% had been reduced to 17.61%.

To improve the childhood immunisation targets, the practice undertook a review of the patient records. Alerts were now being put onto the patient records for patients who had not attended the practice following three invitations for childhood immunisations. Accompanying the invitation letters, the practice now includes the new leaflet for patients whose first language is not English. For patients who did not attend their childhood immunisation appointment, the practice had put a 'Did Not Attend' follow up letter in place. The practice nurse also now contacted patients who did not attend for these appointments. Receptionists were also assisting this process by telephoning the patient's parents to remind them of their appointments.

The practice had reviewed their progress with these new processes in place and at the time of our inspection the childhood immunisation rates had improved with 91% achievement for one year old patients and 95% for two year olds. Staff told us childhood immunisation rates were now being monitored on an ongoing basis to meet the targets.

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 21 June and 5 July 2017, we rated the practice as requires improvement for providing well-led services as the governance arrangements and processes for seeking and acting on feedback from patients required development.

We found these issues had significantly improved when we undertook a follow up inspection of the service on 26 January 2018. The practice is now rated as good for being well-led.

Governance arrangements

At our previous inspection, the practice had some governance arrangements in place; however, there were areas in which these arrangements were under developed.

The practice had failed to analyse and address areas of low achievement in the Quality Outcomes Framework, particularly in relation to its exception reporting. There was a documented staffing structure however, in some areas; responsibilities were shared between staff members, which resulted in a lack of clarity about roles and responsibilities.

As part of the remedial action to improve these issues staff told us they had now assigned leads for various roles within the practice. We saw evidence of an 'Allocation of Tasks and Responsibilities' document which outlined the newly nominated leads for QOF indicators, infection control, prescribing, safeguarding, childhood immunisations and cervical screening. The practice manager told us clinical leads had been allocated in a way to share the workload and in addition, a review of the practice protocols was in progress to support the leads.

At our previous inspection we found information was not always recorded in patient records in a way that was auditable or easily accessible. At our inspection on 26 January 2018 we were provided with evidence that all staff had completed 'Record Keeping' training.

The practice had also undertaken some randomised checks of patient medical records which identified there was a staff issue with understanding the coding including the difference between administration and clinical codes. Coding was discussed at two team meetings and one of the GP partners provided training for various staff members.

The partners had also developed a record keeping audit tool to randomly check patient records. The practice had undertaken three records audits at the time of this inspection, and these showed record keeping had improved and any areas identified for improvement was fed back to individual staff members.

At our previous inspection we found processes were in place to record details of incidents which occurred at the practice, but these required review to ensure that they worked effectively. There was an open and transparent approach to safety and a system in place for reporting and recording significant events; however, there could sometimes be a delay in incidents being formally recorded.

At our inspection on 26 January 2018, staff told us that two significant events had been recorded and these were discussed at the practice team meeting. After discussing the process in order to avoid delays in recording significant events, it was agreed that the person reporting should record the event and be given protected time for this. As a result, the practice 'Significant Event Protocol and Reporting Template' had been updated and we saw evidence of this.

At our previous inspection we found a number of uncollected prescriptions in reception which were several months old. At this inspection we asked the practice manager what process had been developed to address this issue. We were shown evidence of a new repeat prescribing policy which nominated a lead member of staff to monitor the prescription box at reception and staff were instructed that prescriptions not collected within two months were to be removed from the prescription box and passed to one of the GPs for review. To monitor uncollected prescriptions, the practice also showed us evidence of an audit of the prescriptions which was undertaken. During our inspection we reviewed the prescription box and found no prescriptions which were over two months waiting to be collected.

Leadership and culture

At our previous inspection on 21 June and 5 July 2017, we found meetings held within the practice whether these were meetings with external colleagues such as district nurses; or internal practice meetings; were not regularly minuted. At our inspection on 26 January 2018, we asked staff what action had been taken to improve the governance arrangements for meetings within the practice.

Are services well-led?

Good

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

The practice manager showed us evidence of a 'Structure of Meetings' document which outlined the frequency and standing agenda items for the 'Whole Team,' 'Clinical,' 'Partner's,' and the Patient Participation Group meetings. We were also provided with evidence of meeting timetables for these meetings and reviewed meeting minutes which were now being recorded for each of these meetings. The practice manager showed us that minutes of meetings were accessible for staff on the shared drive and were emailed to staff.

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

At our previous inspection on 21 June and 5 July 2017 we found the practice recognised the value of feedback from patients and staff; however, opportunities to gather and act on feedback were not always optimised. The practice did not have an active patient participation group (PPG), and whilst the practice recognised the value of complaints and comments from patients in order to identify areas for improvement; outside of the formal complaints process, arrangements for collecting, analysing and acting on feedback from patients were not well developed.

At our inspection on 26 January 2018, we asked the Practice Manager and GP partners, what action had been taken since our previous inspection to improve the processes for seeking and acting on patient feedback. The practice manager informed us that a Patient Participation Group meeting had been arranged for 31 January 2018 and the Group had been advertised on the practice website and via posters and flyers within the practice. The GPs told us they had invited patients to join the Patient Participation Group at the end of their consultations. At the time of our inspection, the practice manager told us there were 13 patients who had expressed an interest in joining the Patient Participation Group and attending the first meeting. Staff told us as well as updating patients on current services, the Patient Participation Group would be an opportunity to seek feedback from patients.

Staff also told us they were reviewing other methods of gaining patient feedback and as an interim measure, were using the incident book to record feedback on any issues so that any recurring themes or specific issues can be addressed and responded to where appropriate, and these can be included for discussion in the practice team meetings. The practice had also held a team meeting to review the NHS GP Patient Survey for the practice.